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POLICY, PEOPLE, PRACTICE: ENABLING LOCAL RESPONSES TO A GLOBAL PANDEMIC

**CONTRIBUTIONS OF THE U.S. GOVERNMENT-FUNDED POLICY
PROJECT (2000–2006) TO THE HIV POLICY ENVIRONMENT IN
DEVELOPING COUNTRIES**



JANUARY 2006

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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FOREWORD

Over the past 35 years, USAID's Office of Population and Reproductive Health (OPRH) and its partners have led a comprehensive and highly successful effort to improve the enabling policy environment for reproductive health. In 1994, OPRH's Policy, Evaluation, and Communications Division designed the POLICY Project (1995–2006), which not only broadened the focus on reproductive health, but also encouraged work in the field of HIV policy. In the mid-1990s, there was no major international program in place that could help address the many and complex policy needs in countries severely challenged by rapidly increasing HIV prevalence and its consequences. The expansion of the POLICY Project's mandate to include HIV, therefore, was a watershed in international efforts to improve the enabling policy environment in responding to the pandemic. Over the life of the project, POLICY and its many partners carried out hundreds of activities that helped countries improve their national efforts to prevent infections, care for those affected by HIV, and, more recently, provide treatment for people living with HIV.

I am pleased to present to you *Policy, People, Practice: Enabling Local Responses to a Global Pandemic*, which documents the many processes and achievements of the POLICY Project since 2000. This volume is a testament not only to the many people from all walks of life who contributed, but it is also a clear reminder that good policies, strong political commitment, sound planning, effective use of resources, and the full utilization of local capacity are essential components in any successful HIV response.

Despite the many achievements of the POLICY Project, its partners, and others working in this field, the challenges in putting an enabling policy environment in place continue to multiply. Those of us working in the HIV policy field must continue to examine what we are doing and how we can work more effectively to limit the pandemic through policy interventions. Policy work is not easy, especially in the context of HIV. It is by nature political, and in order to be effective, programs must address sensitive issues that historically have been inadequately addressed by public policy. Fostering HIV policy change requires a delicate balance among information, political sensitivities, donor mandates, public opinion, local culture and religion,

and many other factors. We believe this volume will serve as an essential resource to others as we collectively move forward to meet the challenges of improving the HIV policy environment over the next decade.

I would like to commend our staff and partners from more than 30 countries and the United States whose hard work, unending dedication, exceptional skills, and innovative thinking are the main reasons behind the project's success. I would like to pay particular tribute to our many HIV-positive staff whose participation has been and will continue to be central to our work. Not least, thanks to our colleagues at USAID who have supported POLICY's work over the years and have made immeasurable technical contributions to these achievements.

Harry Cross, Ph.D.
Director, POLICY Project, 1995–2006

ACKNOWLEDGMENTS

The POLICY Project is funded by the United States Agency for International Development (USAID) under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. POLICY's HIV work is supported by the President's Emergency Plan for AIDS Relief through USAID. The project is implemented by the Futures Group, a Constella company, in collaboration with the Centre for Development and Population Activities and Research Triangle Institute.

The project would like to recognize our colleagues from USAID for their guidance, technical excellence, and support over the life of the project. In particular, we acknowledge the contributions and guidance of Rose McCullough and Clif Cortez of the Office of HIV/AIDS, Elizabeth Schoenecker, Mai Hijazi, and Diana Prieto of the Office of Population and Reproductive Health, and Billy Pick of the Asia and Near East Bureau. Furthermore, we extend our appreciation to USAID Mission staff, with whom we have collaborated in more than 30 countries around the world, for providing guidance and supporting our work.

Finally, POLICY acknowledges its staff and in-country partners—people living with HIV, government officials, women's and youth groups, faith-based organizations, businesses, the media, and NGOs—who have worked tirelessly to strengthen the enabling environment for HIV programs. This report reflects their achievements and dedication.

EXECUTIVE SUMMARY

REGIONAL ORGANIZATIONS/ PROGRAMS

Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA)

West Africa Regional Program (WARP)

Regional HIV/AIDS Program for Southern Africa (RHAP) (Botswana, Lesotho, and Swaziland)

The Greater Mekong Region





Asia and Near East

Cambodia
China
Egypt
India
Jordan
Nepal
Philippines
Vietnam

Common objectives of HIV programs the world over are to prevent new infections and reduce vulnerability, provide treatment to people living with HIV, and support care for those affected by the pandemic. The massive effort needed to achieve these goals requires an enabling policy environment as its foundation. Lack of proper attention to the policy environment often leads to services that are ineffective, inappropriate, or ill-planned.

This report reflects on the achievements and lessons learned from the POLICY II Project (2000–2006). POLICY's HIV activities are supported by the President's Emergency Plan for AIDS Relief through the United States Agency for International Development (USAID). The strategic objective of the project is to facilitate the development of policies and plans that promote and sustain access to high-quality family planning and reproductive health (FP/RH) programs, including HIV and maternal health. POLICY's HIV activities have been implemented through 27 country offices and four regional programs—bringing the project's presence to over 30 countries around the world. POLICY's efforts have led to the adoption of 33 policies, plans, and strategies at national and regional levels; strengthened networks of people living with HIV in 11 countries and for the Asia and Pacific region; and more than 150 faith- and community-based groups mobilized through small grants to build local capacity to carry out HIV activities.

POLICY operated in a time and context of significant changes in terms of increased resource availability and greater global commitment for addressing HIV. The project's technical and organizational approaches unfolded in ways that were flexible and responsive to changes in the policy environment, yet also sought to provide leadership in guiding global and national policy responses. For example, POLICY played a leading role in analyzing resource needs, understanding program impact, and setting priorities; in increasing civil society participation in policy processes; and in addressing societal factors (e.g., stigma, gender inequality) that increase

HIV vulnerability and limit participation in the response. This broad portfolio is indicative of the way in which the project seeks to address the emerging issues and approaches that are essential for a comprehensive HIV policy response.

POLICY's management philosophy has been that sustainable improvements in a country's policy environment must come from within. In fact, POLICY's success is due, in large part, to the way in which the project conducted its work, relying on in-country nationals and local staff and partners who had knowledge of the local context as well as a long-term presence within the country that allowed them to establish relationships with key decisionmakers and advocacy groups. POLICY sought to ensure that solutions and strategies for local needs and issues were not externally imposed. Working with and building capacity of in-country partners and staff has also been a vital means for encouraging sustainability of policy processes and mechanisms.

Another guiding philosophy for the project is to operationalize the principle of greater involvement of people living with HIV and vulnerable groups. These efforts are evident in the project's staffing and in the selection of partners with whom we have collaborated.

POLICY has identified five pathways or technical focus areas that are essential for creating an enabling environment. These core areas include policy formulation, leadership and advocacy, resources and data for decisionmaking, reducing vulnerability, and multisectoral engagement. If any aspect is neglected, the integrity of the policy environment is compromised.

#1: POLICY FORMULATION

POLICY is dedicated to helping partners in developing countries strengthen the policies, strategic plans, and operational guidelines through which effective HIV responses can be built and implemented. Policies are the starting point for successful programs and services. They articulate a country's vision, commitment, priorities, and goals. Strategic plans and budget allocations support the implementation mechanisms and outline the roles and responsibilities to facilitate putting policies into practice. Operational guidelines are the laws, regulations, and codes that guide implementation of all aspects of how programs and services are provided. Policies, strategic plans, and operational guidelines are particularly important for HIV programs given the need to coordinate multisectoral responses, allocate and use resources wisely, adapt to breakthroughs in addressing HIV, and reduce stigma and protect the rights of vulnerable groups.

The project's approach recognized that the policy process encompasses a number of steps—from the identification of policy issues to policy dialogue and formulation to mobilization of resources to monitoring and evaluation of policy implementation. The project has learned that policies are more responsive and have a greater likelihood of effective implementation when developed in a participatory manner. Involvement of various stakeholders promotes ownership, expands support for implementation, and takes into account the needs and assets of the different groups. POLICY worked to build capacity of various stakeholders, from government officials to NGOs and businesses to people

living with HIV and vulnerable groups. This attention to human capacity development has been essential for ensuring that policy responses are sustainable and based on locally determined priorities and goals.

#2: LEADERSHIP AND ADVOCACY

Bold leadership at all levels, and from across sectors, is needed to catalyze responses to the pandemic. Leadership is essential for keeping HIV on the national agenda, for breaking the silence and stigma surrounding HIV, and for mobilizing and coordinating responses. Countries that have demonstrated strong leadership are the ones that have had greater success in addressing the pandemic. Inspiring dedicated, authentic leadership remains one of the greatest challenges in the HIV response. When leaders speak out on HIV, however, it can help give those most affected by the pandemic the courage to come forward and it can facilitate community dialogue on issues surrounding HIV. Ending the silence is critical for averting future infections and ensuring high-quality treatment and care. Through advocacy, policy champions can carry out targeted actions to promote dialogue on specific HIV policy issues and encourage commitment for addressing those issues.

POLICY's leadership and advocacy work has focused on government leaders, people living with HIV and vulnerable groups, and faith- and community-based leaders. These groups are integral to efforts to bring about the changes needed to ensure an effective HIV response—including influencing community attitudes, marshalling support and resources for policies and programs,

and improving understanding of the pandemic and its impact on those most affected. The goal has been to strengthen policy champions within public, civil, and private sectors who can effectively advocate for policy change. In particular, POLICY sought to position people living with HIV at the center of the response. They are intimately aware of the types of strategies needed to improve prevention, treatment, and care. Involving people living with HIV enhances policies and programs, not only for HIV-positive people, but for the broader community as well.

#3: RESOURCES AND DATA FOR DECISIONMAKING

Despite increased funding for prevention, treatment, and care, resources for HIV remain inadequate—there is still tremendous need for allocating and using resources efficiently and for avoiding waste and duplication of effort. Effective service delivery demands that wise decisions be made at the policy, planning, and budgeting stages. To do this, accurate data are needed to inform evidence-based decisionmaking, including data on the scope of the epidemic, the populations that are affected, the costs and coverage of services, and the likely impact of different strategies. In addition, absorptive capacity, in terms of the human capacity and the infrastructure needed to take in and effectively use new resources, is a significant issue that countries will need to address to successfully scale-up programs and services.

POLICY has been at the forefront of developing—and building capacity in utilizing—user-friendly, innovative, interactive, and adaptable

tools and models to improve planning and financing of HIV policies and programs. With these tools and technical assistance, government officials in charge of planning and budgeting are better able to do their jobs, while civil society policy champions can play a role in the process and advocate for needed strategies and investments. POLICY's efforts have led to an improved understanding of the scale and impact of the pandemic, the costs and effectiveness of various interventions, the resources needed (e.g., funding, training requirements), and the coverage of prevention, treatment, and care services.

#4: REDUCING VULNERABILITY

The next five years could prove to be a real turning point in the world community's response to the pandemic. Medical advances and new resources have the potential to dramatically slow the progression of HIV to AIDS, enabling people living with HIV and their families to maintain a higher quality of life for a longer period of time. However, realizing this shift in the pandemic and averting future infections depends, fundamentally, on how policies and programs include and address the needs of affected groups. These groups include people living with HIV, women, youth and orphans and vulnerable children, the poor, and vulnerable groups, such as prostitutes, men who have sex with men (MSM), and injection drug users (IDUs). Despite the best of intentions, efforts to expand prevention, treatment, and care are doomed for failure if they do not adequately address the factors that increase vulnerability to HIV infection and if they do not consider the needs of the most vulnerable

groups. To do so, countries must devise strategies to counter stigma and discrimination, gender inequality, and poverty, and must take special steps to protect youth and orphans and vulnerable children.

As POLICY's HIV work expanded, the project made addressing stigma, discrimination, and human rights a priority. As a result of this attention, the project brought new partners into the policy arena, strengthened the capacity of people living with HIV and vulnerable populations, and enhanced policies and guidelines. With extensive FP/RH experience, POLICY has a history of integrating gender considerations into each aspect of our work. With regard to HIV, the project provided technical leadership regarding issues such as women and HIV, gender-based violence, masculinity, HIV-positive women's leadership, gender integration methods, and gender and policymaking tools. Furthermore, POLICY worked with governments and civil society partners to develop policies to ensure that the needs of youth and orphans and vulnerable children are reflected in responses to the pandemic.

#5: MULTISECTORAL ENGAGEMENT

The pandemic is a development challenge that has an impact on all sectors and groups in society. Given this, a multisectoral policy response is required—such an approach improves coordination, strengthens implementation and accountability, and increases the resources and skills brought to the response. Countries have greater success in combating HIV when they enact programs that build on the synergy of multisectoral

efforts; if key sectors or groups are neglected or isolated, HIV will continue to make inroads.

POLICY has encouraged multisectoral engagement in three main ways: improving coordination among government ministries and across levels (e.g., national, district); bringing new partners into the HIV arena (e.g., businesses, faith-based organizations, NGOs); and building government/civil society/private sector partnerships. The national government is a significant player in creating an enabling environment for HIV programs given its authority to develop and adopt policies, laws, and budgets. However, the nature of the pandemic requires that it not be addressed by the national health department alone. Each ministry, agency, and level of government can address a different aspect of the pandemic and bring additional resources and capacity to the country's response. While the policy arena has traditionally been the domain of government officials, POLICY recognizes the importance of involving civil society and private sector partners in combating the pandemic. These groups are often better positioned to reach vulnerable groups and are integral to breaking the stigma and silence surrounding HIV. POLICY assisted groups such as businesses and faith-based organizations to design HIV policies and strategies to meet the needs of their employees and communities. Furthermore, POLICY's experience with both the government and civil society and private sectors helped the project serve as a bridge between different sectors in some countries, enabling government, civil society, and the private sector to come together to improve policies and programs.

REFLECTIONS: LESSONS LEARNED AND FUTURE CHALLENGES

The HIV policy environment has changed dramatically over the past five years. In many cases, POLICY has seen its efforts lead to sustainable policy processes and replicable approaches within countries and communities. In other cases, the project's work has broken new ground and planted the seeds for future policy work. POLICY's achievements demonstrate the myriad ways that the policy environment contributes to meeting prevention, treatment, and care goals. While it is difficult to sum up all that the project has learned, the following fundamental principles have emerged:

- An enabling policy environment is the glue that holds the core elements of effective HIV responses together.
- Proper attention at the policy development stage lays the foundation for more effective program implementation and scale up.
- Policies and programs are significantly improved when people living with HIV and members of vulnerable groups play a leading role in the HIV response.
- Leaders and policy champions promoting change from within—whether in a government department, a faith-based group, NGO, or a business—are essential for galvanizing HIV responses.

- Programs have greater impact and sustainability when policies consider the best available data regarding resource needs (e.g., funding levels, human capacity), current and desired service coverage, and the extent and impact of the epidemic in the local context.
- Mitigating the factors that exacerbate vulnerability—including stigma, discrimination, human rights violations, gender inequality, and poverty—holds the key for making real inroads in responding to the pandemic. The success of prevention, treatment, and care depends on empowering and meeting the needs of society's most vulnerable groups.
- Integration of FP/RH and HIV programs can be cost-effective in the long run and leads to benefits for both programs. Successful integration requires addressing operational issues and fostering recognition of the FP/RH needs of people living with HIV and vulnerable groups.

CONCLUSION: LINKING POLICIES AND PROGRAMS

What makes the policy environment particularly important, including for HIV responses, is the link between policy development and program implementation. Policy development is valuable both as a process and as an outcome. As a process, policies that come about through a participatory, broad-based manner can:

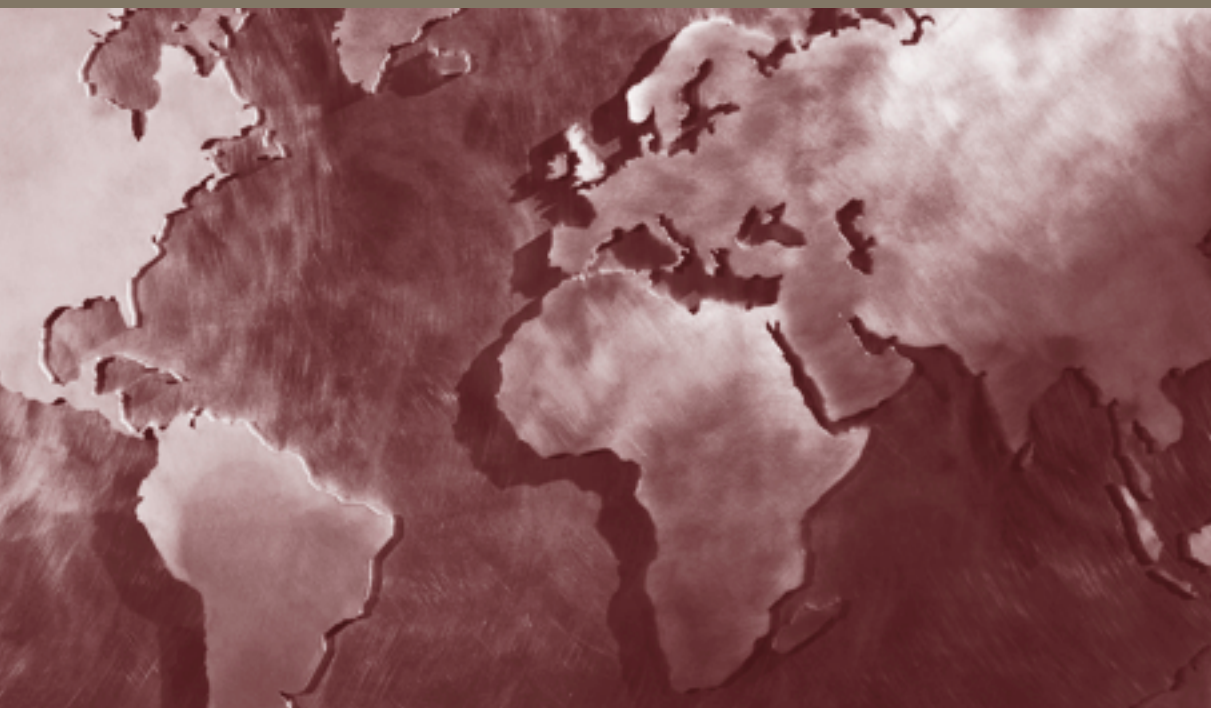
- Build cooperative relationships and networks that will facilitate implementation;
- Educate the various stakeholders of the viewpoints, needs, and assets of other affected groups;
- Encourage consensus on priority issues and approaches;
- Promote ownership and buy-in across sectors;
- Empower those who take part in the process;
- Promote open community dialogue on policy issues and break the silence surrounding HIV; and
- Bestow greater legitimacy on the policy approaches adopted, thereby increasing likelihood of effective implementation.

As an outcome, policies support implementation by:

- Outlining goals, strategies, roles, and responsibilities;
- Serving as evidence of the government's or organization's commitment to addressing HIV;
- Giving authority to various stakeholders to undertake activities to meet goals and objectives;

- Ensuring continuity and stability in a country's overall response, even though individual leaders or stakeholders may change;
- Improving implementation and enhancing consistency at the service and program delivery level; and
- Establishing mechanisms to protect the rights of various groups, including people living with HIV, vulnerable groups, women and youth, healthcare workers, employees, and so forth.

For these reasons, successful program implementation and scale up—especially of the magnitude required to meet future HIV prevention, treatment, and care goals—are dependent on creation of enabling policy environments. POLICY's body of work and achievements demonstrate the diverse ways in which policy development is integral to the success of HIV prevention, treatment, and care interventions and, ultimately, to the ability of countries to avert future infections and improve the quality of life of those most affected.



INTRODUCTION



THE POLICY PROJECT AND THE CHANGING HIV POLICY LANDSCAPE





PHOTO CREDIT: PALANI MOHAN

“There has been a sea change in the global AIDS response since 2001. Global funding has increased from roughly US\$2.1 billion to an estimated US\$6.1 billion in 2004, and access to key prevention and care services has improved markedly (UNAIDS, 2004[a]). The number of secondary-school students receiving AIDS education has nearly tripled, the annual number of voluntary counseling and testing clients has doubled, the number of women offered services to prevent mother-to-child transmission has increased by 70%, and the number of people receiving anti-retroviral therapy has increased by 56%, according to a recent survey in 73 low- and middle-income countries which represent almost 90% of the global burden of HIV (POLICY Project et al., 2004) ... Despite the improvements, however, coverage remains uneven and, in several respects, highly unsatisfactory ... Business as usual spells disaster. A massive effort is needed to achieve a response on a scale that matches that of the global AIDS epidemic.”

~ UNAIDS, 2004b, pp. 5–6



PHOTO CREDIT: COREL

Since HIV and AIDS first emerged on the world stage nearly a quarter of a century ago, the global community has learned a great deal about the type of “massive effort” needed to cope with the pandemic. Experience has demonstrated the need to address HIV as a multisectoral issue; to facilitate prevention, treatment, and care; to empower and involve affected communities in the response; to use human and material resources wisely; to encourage strong, open leadership; and to break down the barriers of stigma, discrimination, and gender inequality. In many ways, we know why we must act and when, we know who must be involved, and to some extent, we know what we must do. The persistent question that remains, then, is: *How can we do it?*

The POLICY Project and our in-country partners have worked to help answer this very ques-

tion. The massive effort needed to scale up HIV programs and services requires an enabling policy environment as its foundation. The policy environment encompasses several factors, including:

- The collection and analysis of data to support evidence-based decisionmaking, build political commitment and popular support, and monitor progress;
- The dynamics that govern who participates in the policymaking process (e.g., Whose voices are heard? Who has the skills and capacity to participate?);
- The articulation of specific policies, plans, and operational guidelines to guide the implementation of programs and services; and
- The allocation and mobilization of resources (e.g., funding, human capacity development, training) to

further support translating policies into practice.

In myriad ways, an enabling policy environment helps communities and countries avert HIV infections, offer treatment to people living with HIV, and provide care and support. The POLICY Project seeks to create an environment in which people living with HIV are not stigmatized; relevant stakeholders have the capacity, skills, and opportunities to meaningfully participate in the policy process; and human and material resources are harnessed to address priority action areas. In a truly enabling policy environment, for example, laws and regulations can help ensure that women in Kenya have the right to own and inherit property, providing them access to resources and reducing their and their children’s vulnerability to HIV. In such an environment, businesses in Ethiopia, Mexico, and South Africa will adopt and implement work-

BOX 1

POLICY ACHIEVEMENTS AT-A-GLANCE

In considering POLICY's contribution to an enabling HIV policy environment from July 2000–June 2005, the following illustrative achievements are noted:

- 33 national or regional HIV policies, strategies, and strategic plans approved in 12 countries and for the Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA) region
- Subnational strategic plans developed and adopted in three countries
- Sectoral policies on issues such as gender, armed forces, orphans and vulnerable children, and faith-based organizations adopted in eight countries and for the Southern Africa region
- Workplace policies adopted in three countries
- Organizations/councils formed to coordinate the HIV response in three countries
- Policy change promoted in the Global Fund community leading to participation of people living with HIV in Country Coordinating Mechanisms (CCMs) in three countries
- Additional resources mobilized in 10 countries and for the Southern Africa region
- Improved efficiency of resource allocation in four countries as a result of Goals modeling
- 29 advocacy coalitions formed and strengthened in 12 countries and in the Southern Africa region
- Networks of people living with HIV formed or strengthened in 11 countries and in the Asia region
- Myriad community- and faith-based groups and coalitions strengthened
- Nearly 150 small grants awarded to community- and faith-based organizations
- Advocacy presentations and publications based on the AIDS Impact Model completed in 12 countries and three regions
- Multiple assessment tools for the HIV policy and program environment implemented worldwide

place policies and programs to prohibit discrimination against employees affected by HIV. And strategic plans and budget allocations will facilitate access to reliable supplies of antiretrovirals (ARVs) for people living with HIV in Vietnam.

The POLICY Project—which receives funding from the President's Emergency Plan for AIDS Relief through the United States Agency for International Development (USAID)—is dedicated to helping partners in developing countries strengthen

the policy foundation on which effective HIV responses can be built. The project's strategic objective is to facilitate the development of policies and plans that promote and sustain access to high-quality family planning and reproductive health (FP/RH) programs, including HIV and maternal health. To achieve POLICY's strategic objective, the project endeavors to:

- Broaden and strengthen political and popular support;

- Improve planning and financing for FP/RH and HIV;
- Ensure that accurate, up-to-date, and relevant information informs policy decisions; and
- Enhance in-country and regional capacity to provide policy training.

Illustrative examples of POLICY's achievements in creating enabling policy environments for HIV programs are presented in Box 1.

GLOBAL HIV POLICY INITIATIVES

From 2000 to 2005, the world witnessed the emergence of new challenges and opportunities in the treatment of HIV and AIDS. By 2000, triple-combination therapies had been shown to be effective in slowing the progression of HIV to AIDS. Early research results also indicated that a single dose of nevirapine given to a woman during labor could dramatically reduce—and in many cases prevent—mother-to-child transmission (MTCT) of HIV. Despite an agreement with leading pharmaceutical companies in May 2000 to reduce prices, however, the cost of ARVs put treatment out of reach for the vast majority of people in the developing world, most of whom were living on \$1–\$2 per day. In 2000, fewer than 4 percent of people living with HIV in the developing world were on ARVs. Today, even with the availability of generic, more affordable ARVs, countries continue to struggle to develop the infrastructure, systems, and human capacity needed to scale up reliable, sustainable treatment initiatives.

By 2000, the policy response in most developing countries had been slow in coming. Only a few countries—notably Brazil, Thailand, and Uganda—had implemented comprehensive, national public health programs to slow or reverse the course of the epidemic. In terms of recognizing the human toll of the pandemic, government leaders embraced the Greater Involvement of People Living with HIV/AIDS (GIPA) Principle at the Paris Summit in 1994. Five years after the summit, however, UNAIDS lamented that little progress had been made in making the GIPA Principle a reality (UNAIDS, 1999). Ending stigma and discrimination became the theme for two World AIDS Days (2002 and 2003), yet stigma continues to drive the pandemic underground and is a leading barrier, if not the most intractable challenge, for implementing effective prevention, treatment, and care programs. The impact of the pandemic on vulnerable groups—such as women, the poor, youth, and the most at-risk populations—has become clearer to world leaders. For example, in 2002 and 2004, NGOs and international groups

mobilized a YouthForce at the International AIDS Conferences; in early 2004, UNAIDS launched the Global Coalition on Women and AIDS; and international mechanisms such as the Millennium Challenge Accounts and the Millennium Development Goals have recognized the links among poverty, vulnerability, HIV, and national development. Even with these efforts, in many African countries, the majority of new infections occur in women and young people, while in Asia and Latin America, vulnerable groups such as prostitutes, injection drug users (IDUs), and men who have sex with men (MSM) still face stigmatization and human rights violations.

The past five years have witnessed significant growth in the mobilization of political will and resources. In preparation for the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS), a team of researchers estimated that by 2005, \$9.2 billion would be needed annually for prevention, treatment, and care and support (Schwartländer et al., 2001) (see Box 2). Evidence from this

study helped bolster United Nations Secretary-General Kofi Annan's call in April 2001 for the creation of an international fund to support initiatives to combat HIV and other infectious diseases. With the UNGASS Declaration of Commitment on HIV/AIDS, heads of state acknowledged the pandemic as a social, economic, and development issue requiring urgent attention. They also pledged to reach goals and targets in terms of prevention; care, support, and treatment; reduction of vulnerability; and impact mitigation. For example, the declaration called on countries to develop and implement multisectoral national strategies and financing plans by 2003. Aspects such as respect for human rights and the need to address gender inequality were also highlighted in the declaration.

Growing political commitment was accompanied by the mobilization of additional resources for HIV. By 2002, the goal of setting up a Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) had come to fruition, including the selection of the Secretariat and award of the first round of grants to 36

countries. In the following year, the World Health Organization (WHO) launched the "3 by 5" Initiative, which sought to treat three million people living with HIV with ARVs by 2005. In that year, the United States also established the President's Emergency Plan for AIDS Relief, which pledges \$15 billion over five years and aims to treat two million people living with HIV, avert seven million new infections, and provide care and support to 10 million people affected by the pandemic, including orphans and vulnerable children. Throughout the past two decades, the U.S. Government has been the leading donor for international HIV programs; it is also the largest contributor to GFATM. The President's Emergency Plan significantly increased resources for highly-affected countries and reorganized all U.S. Government-sponsored HIV work under the leadership of the Global AIDS Coordinator, who holds the rank of ambassador. (For POLICY's contribution to the Emergency Plan focus countries, see "In Focus 1" on page 14.) In 2004, recognizing the need to coordinate efforts, maximize new

BOX 2 **THE CALL FOR \$10 BILLION** **TO COMBAT HIV**

In the June 21, 2001, edition of *Science*, a team of researchers—including POLICY Project staff—published a seminal study estimating the resources needed to combat the pandemic (Schwartländer et al., 2001). The team estimated that, by 2005, \$4.8 billion would be needed for a package of 12 essential prevention programs and an additional \$4.4 billion would be needed for nine key treatment, care, and support interventions. This funding, it was argued, could come from a mix of domestic and donor resources.

Findings from this study supported the call for a global fund, which Kofi Annan estimated to be \$7–\$10 billion. The estimates suggested that, at minimum, \$9.2 billion would be required annually by 2005 for an expanded HIV response. A follow-up study estimated that 29 million new infections could be averted by 2010 by fully funding and implementing the package of prevention activities (Stover et al., 2002).

Computer models (such as the SPECTRUM Suite and Goals Model) developed by Futures Group/POLICY and others helped researchers estimate the costs, coverage, and impacts of different interventions.



PHOTO CREDIT: PALANI MOHAN

resources, and avoid duplication, the United Nations, the United States, and leading international donors around the world committed to the “Three Ones” principle. This agreement calls for one integrated national action plan for each country, one national coordinating body for HIV, and one country-level monitoring and evaluation system.

POLICY’S TECHNICAL APPROACH

FIVE PATHWAYS TO AN ENABLING POLICY ENVIRONMENT FOR HIV RESPONSES

It was against this backdrop—of new opportunities and persistent challenges—that the POLICY II Project commenced. Building on work begun during POLICY I (1995–2000) to influence the FP/RH and maternal health policy environment,

POLICY II also focused on ways to strengthen the HIV enabling environment through multiple entry points. The nature of work under this phase shifted dramatically, both in magnitude and technical focus. Early in the project, funding for HIV increased significantly and, by the end of the project (FY05), HIV accounted for more than 60 percent of total funding obligations. Our HIV activities have been implemented through 27 country offices¹ and four regional programs²—bringing POLICY’s presence to over 30 countries in Africa, Asia and the Near East, Europe and Eurasia, and Latin America and the Caribbean.

When POLICY II began, the project’s HIV portfolio focused on Africa and involved assisting governments to formulate national policies and strategic plans, using the AIDS Impact

Model to raise awareness on the dimensions and future course of the pandemic, and building national political commitment. While this approach continues, POLICY has greatly diversified its work to meet the newly emerging demands and circumstances of the pandemic. This effort has translated into a strong focus on strengthened leadership, community participation, and a sustainable multi-sectoral response. A holistic approach to policy development is needed. POLICY is concerned not only with the drafting of policies and plans. It also works to ensure that there is broad participation in the process; that leaders are strengthened and mobilized across sectors; that accurate data are used to encourage evidenced-based decisionmaking; that plans consider the most effective and equitable allocation of resources; and that

1. Cambodia, China, Egypt, Ethiopia, Ghana, Guatemala, Haiti, Honduras, India, Jamaica, Jordan, Kenya, Malawi, Mali, Mexico, Mozambique, Nepal, Nigeria, Peru, Philippines, South Africa, Tanzania, Uganda, Ukraine, Vietnam, Zambia, and Zimbabwe.

2. Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA), West Africa Regional Program (WARP), Regional HIV/AIDS Program for Southern Africa (RHAP) (Botswana, Lesotho, and Swaziland), and the Greater Mekong Region.

societal factors that may limit participation or increase vulnerability are addressed.

POLICY's technical approach to HIV policy unfolded in a way that was flexible and responsive to changes, yet also provided technical leadership to help guide the response. For example, POLICY played a leading role in analyzing resource needs, understanding program impact, and setting priorities; in increasing civil society participation in policy processes; and in addressing factors such as stigma and discrimination and gender inequality. POLICY's broad portfolio of HIV work is indicative of the way in which the project continually sought to address the emerging issues and approaches that are essential for a comprehensive HIV policy response. The project's technical approach can be divided into five core technical areas,

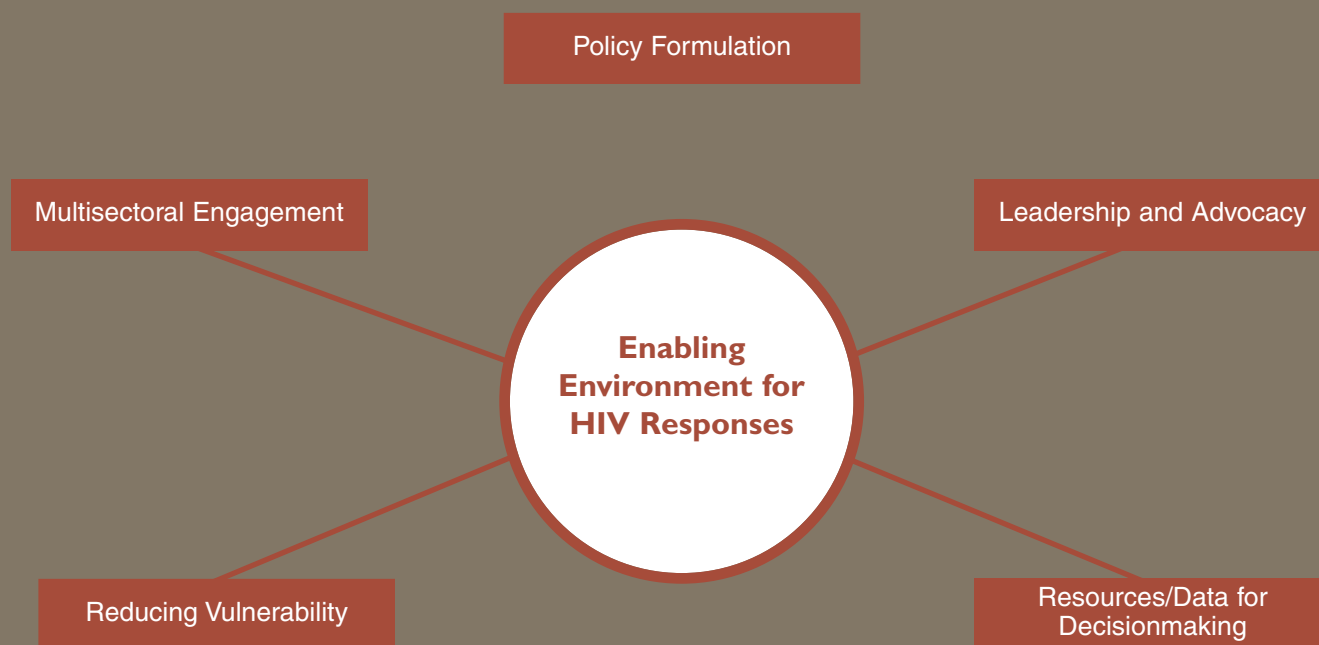
which are intertwined and essential for creating an enabling policy environment (see Figure 1).

- **Policy formulation.** POLICY works with in-country partners to improve policy, program, and operational approaches at national, community, and organizational levels. Policies articulate a country's vision, priorities, and goals while strategic plans identify the steps that government and other stakeholders will take in order to achieve goals and objectives established in policies. Operational guidelines detail the mechanisms and procedures for carrying out specific tasks, whether it is establishing support structures and minimum standards for home-based care or providing free ARVs through the public health system. Taken as a whole, these policies,

strategic plans, and operational guidelines provide the foundation for implementing effective HIV responses.

- **Leadership and advocacy.** People from all walks of life—including government officials, people living with HIV, faith-based and business leaders, women and youth, journalists and healthcare workers, and members of affected communities—have important leadership roles to play. POLICY builds the HIV-related skills and capacity of policy champions who can then advocate for change. Advocacy involves targeted actions directed at decision-makers to promote policy change on specific HIV issues. Leaders and advocates can keep HIV on the national agenda, break the silence surrounding HIV, provide direction for the formulation of policies, help mobilize

FIGURE 1. FIVE PATHWAYS TO AN ENABLING ENVIRONMENT FOR HIV RESPONSES



resources, support coordination and sustainability of responses, and make certain that lessons from successful activities are incorporated into policies and programs.

- **Resources and data for decisionmaking.** Use of data and sound planning helps support the emergence of well-informed policies and strategies. POLICY has extensive experience in HIV projections and estimates, which improves understanding of

epidemic dynamics and enhances strategic planning efforts. The project also assists leaders in analyzing different resource needs and allocation patterns to enable countries and organizations to target and use their resources cost-effectively. At the national level, POLICY helps countries identify gaps in current spending plans, as well as routinely monitor and evaluate the impact of interventions. POLICY also provides support to governments

and civil society and private sector groups as they prepare proposals for additional funding, thereby increasing their chances of being awarded these funds.

- **Reducing vulnerability.** POLICY's cross-cutting issues—issues that are integrated into each aspect of the project's work—are to promote human rights and reduce stigma and discrimination, encourage gender-sensitive responses,

and address the needs of youth and orphans and vulnerable children. Despite the best of intentions, HIV programs are doomed for failure if they do not adequately address the factors that increase vulnerability to HIV infection or consider the needs of the most vulnerable groups.

- **Multisectoral engagement.**

Strategies to prevent the spread of HIV, to care for those affected, and to mitigate the impact of the pandemic require mobilizing and coordinating efforts across all sectors and involving affected stakeholders. Multisectoral engagement is particularly critical for reducing stigma and discrimination, harnessing resources to complement government efforts, encouraging ownership and implementation of HIV programs, and addressing the various factors that increase vulnerability across sectors. POLICY has been well-positioned to promote multisectoral engagement by improving coordination across government ministries and levels, bringing new partners into the HIV policy arena, and

encouraging collaboration among government, civil society, and the private sector.

POLICY'S ORGANIZATIONAL APPROACH

TEAMING WITH LOCAL PARTNERS TO IMPROVE IN-COUNTRY POLICY ENVIRONMENTS

POLICY's management philosophy has been that sustainable improvements in a country's policy environment must come from within. This philosophy guides how the project carries out its work. In our model, local expert staff and partners work with multiple stakeholders to bring about and implement locally-determined policies and programs. External technical assistance is important, but is targeted at introducing new technical approaches, facilitating global leadership initiatives, and supporting country programs through sharing of successful practices and lessons from other countries' experiences. The bulk of POLICY's field-level work is accomplished by dedicated, technically competent local staff drawn from within the

country itself (see "Policy | People | Practice 1"). The project has taken steps to empower in-country staff and to institutionalize capacity among partners and local organizations. This approach has been essential for understanding and influencing the local HIV policy environment and ensuring sustainability of policy responses.

Another guiding principle for the project has been the importance of expanding participation in the policy process to include people living with HIV and other communities affected by the pandemic. POLICY's commitment to meaningful participation has become a core value of our work in both FP/RH and HIV. The first phase of the POLICY Project began after the 1994 International Conference on Population and Development, which highlighted the need for civil society participation in reproductive health issues and a comprehensive approach to meeting reproductive health needs. Under POLICY II, the project's approach to the HIV policy environment continued to place high value on participation, local ownership, and human capacity development,



PHOTO CREDIT: BONNY JENNINGS FOR THE USAID RHAP PROGRAM

particularly for those most affected. Involvement of people living with HIV and other vulnerable groups greatly enhances policies and programs. These groups are the experts when it comes to understanding the prevention, treatment, and care needs of those affected by the pandemic. POLICY has worked to operationalize the principle of greater involvement of people living with HIV and vulnerable groups in all aspects of our work (for an example, see “In Focus 3” on page 96).

The remainder of this report explores POLICY’s contributions to creating enabling environments for HIV responses based on the project’s five core

technical areas. The sections include tables that highlight illustrative examples of POLICY’s achievements in each technical area and demonstrate the ways in which the policy environment supports prevention, treatment, and care efforts. Each technical area is essential for establishing and sustaining comprehensive, appropriate responses, and the greatest impact is realized when all elements work together. The report concludes by reflecting on lessons learned for future HIV policy work. Ultimately, lack of proper attention to any aspect of the policy environment will result in ineffective, inappropriate, or ill-planned programs and services.

1

LOCAL STAFF KEY TO POLICY SUCCESS

Over the life of the project, POLICY has learned that how POLICY does its work is as important as what it accomplishes. Much of POLICY's work in building enabling policy environments within countries is accomplished by the project's dedicated field staff—locally-based country directors, resident advisors, technical specialists, and others—who bring expertise and support to the policy process on the ground.

A core element of POLICY's approach has been to mentor in-country staff to enable them to lead activities with limited assistance from POLICY's Washington, D.C.-based staff. Field staff strengthen their own leadership and technical skills and gain valuable experiences during their tenure with the project and, in the process, become trusted HIV policy experts within their countries. At the same time, in-country staff often bring extensive credentials of their own to the project. For example, the POLICY/Nepal Country Director is a former Home Secretary, and POLICY/Vietnam's Country Director served as the Director of Information, Education, and Communication for the National Committee for Population and Family Planning.

The ability to draw on locally respected field staff has enabled the project to influence HIV policy environments in positive ways. For example, the POLICY/Kenya Country Director co-led the National AIDS Control Council's Gender and HIV/AIDS Technical Subcommittee that drafted guidelines for mainstreaming gender into the country's HIV strategic plan. POLICY/Ukraine staff members have supported the Ministry of Health and other stakeholders in designing the National Voluntary Counseling and Testing (VCT) Protocol. The POLICY/Malawi Country Director was a member of the task force and equity strategy drafting team that outlined the country's five-year, free ARV program. And in Mexico, a POLICY resident advisor has been instrumental in supporting stigma-reduction projects and private-public partnerships, including the National Business Coalition on HIV/AIDS.

Contributions by local field staff, who have nurtured relationships with key stakeholders within the government, civil society, and private sector, have been essential to achieving POLICY's mission of promoting policies and plans that facilitate and sustain access to high-quality HIV and reproductive health programs.

POLICY'S CONTRIBUTIONS TO THE EMERGENCY PLAN FOCUS COUNTRIES

Cornerstones of the President's Emergency Plan are to bring about "the creation of sound enabling policy environments," encourage "bold national leadership," and implement "strong strategic information systems" (Tobias, 2004). These priorities are reflected in the work POLICY carries out in 10 of the 15 Emergency Plan focus countries.

- **Botswana.** POLICY has supported life skills programs for more than 2,000 orphans and vulnerable children, using community mobilization and advocacy skills development targeting faith-based organizations and NGOs. Improved care and support have been provided to more than 6,000 people living with HIV as a result of palliative care training in partnership with the Nurses Association of Botswana. POLICY has also started a project aimed at improving the policy environment to support increased uptake of VCT.
- **Ethiopia.** POLICY, through the White Ribbon Alliance and in collaboration with the Hareg Project, has been at the forefront of efforts to integrate prevention of mother-to-child transmission (PMTCT) into safe motherhood programs, thereby responding to the needs of women and their children.
- **Haiti.** POLICY has strengthened strategic information, policy analysis, and data use related to stigma, discrimination, orphans and vulnerable children, resource allocation, projections, estimates, and VCT. The project has trained more than 250 people in policy-related skills. Leadership-building activities have been targeted to people living with HIV and representatives of faith-based organizations to ensure increased community participation in HIV programs and services.
- **Kenya.** POLICY has promoted improved resource allocation and mobilization for Kenya's national HIV strategies. The National AIDS Control Council is using POLICY resource needs estimates to mobilize government, donor, and private funding. The World Bank has already committed an additional US\$30 million to implement the 2005–2010 national HIV strategy. POLICY has also mobilized thou-

sands of people living with HIV and community leaders to tackle stigma and discrimination by forging relationships with a range of national networks. Furthermore, groundbreaking work has commenced in partnership with legal and traditional structures to promote women's access and rights to property ownership and inheritance.

- **Mozambique.** In partnership with the Ministry of Health's Multisectoral Technical Group, POLICY assisted in preparing current HIV impact projections. Multisectoral engagement has led to greater accuracy and more widespread use of the information. Production and dissemination of HIV fact books and other presentations has led to increased data use and evidence-based decision-making.
- **South Africa.** POLICY has worked with various national and provincial governments to devise HIV policies, plans, and guidelines, including workplace guidelines for the public sector. In addition, POLICY has been instrumental

in supporting community outreach for HIV prevention. The project provided training to more than 500 traditional leaders who, in turn, have reached an estimated 3.5 million South Africans with campaigns to promote abstinence and being faithful.

- **Tanzania.** POLICY contributed to improving the country's HIV policy environment by providing the Ministry of Justice and Constitutional Affairs and the Tanzania Women Lawyers Association with technical assistance for the review of existing laws and preparation of recommendations for the national HIV bill currently under development.
- **Uganda.** POLICY has actively supported leadership building and community mobilization with vulnerable groups. In partnership with the National Forum of People Living with HIV/AIDS in Uganda and the Uganda Women Lawyers Association, a series of publications—including a guide on where to access HIV care and support, a guide on how to write a will, and a human rights information

booklet—have been produced and distributed.

- **Vietnam.** POLICY has contributed to improving treatment and care options of people living with HIV by supporting the development of Vietnam's first national HIV-positive network. The network has focused on increasing treatment knowledge and literacy among people living with HIV linked to increasing awareness of their human rights. POLICY also worked with the government to revise the national ARV guidelines and serves as the lead agency in devising national guidelines on palliative and nursing care for people living with HIV.
- **Zambia.** POLICY helped establish referral centers to provide palliative care for people living with HIV. By providing technical assistance to the Zambia Interfaith Networking Group on HIV/AIDS, POLICY facilitated the formation of faith-based support groups for people living with HIV. Through small grants, POLICY also built the capacity of 11 district HIV/AIDS task forces.

POLICY FORMULATION



PHOTO CREDIT: VLAD KONDRATUK

POLICY collaborated with government leaders, including Dr. Nadiya Zhylka of Ukraine's Ministry of Health, to develop the country's new national PMTCT strategy for 2005–2011.



POLICY FORMULATION



Working group of HIV-positive leaders from Arequipa, Trujillo, Lima, Callao, and Tumbes at the July 2005 strategic planning workshop of Peruanos Positivos.



PHOTO CREDIT: ROSA BEJAR

POLICY BRIEF: POLICY FORMULATION

- An enabling policy environment lays the foundation for effective, sustainable programs and services.
- The policy process encompasses a number of steps—from the identification of policy issues to policy dialogue and development to mobilization of resources to monitoring and evaluation of policy implementation.
- Policies are more responsive and have a greater likelihood of effective implementation when developed in a participatory manner.
- Policies and plans are particularly important for HIV programs given the need to coordinate multisectoral responses, allocate and use resources wisely, adapt to breakthroughs in addressing HIV, and reduce stigma and protect the rights of vulnerable groups.



PHOTO CREDIT: PALANI MOHAN

Policies are the starting point for successful programs and services—they lay the foundation on which appropriate, sustainable programs can be built and implemented. At the national level, policies are essential for creating an enabling environment because they articulate a country's framework for addressing key issues. In general, policies and plans seek to:

- Help create a common vision regarding what the country or society strives to achieve;
- Establish authority and legitimacy;
- Obligate the government to take appropriate legislative, regulatory, economic, and other measures to achieve goals and objectives;
- Outline the framework for developing programs, organizational structures, strategic planning, and implementation;

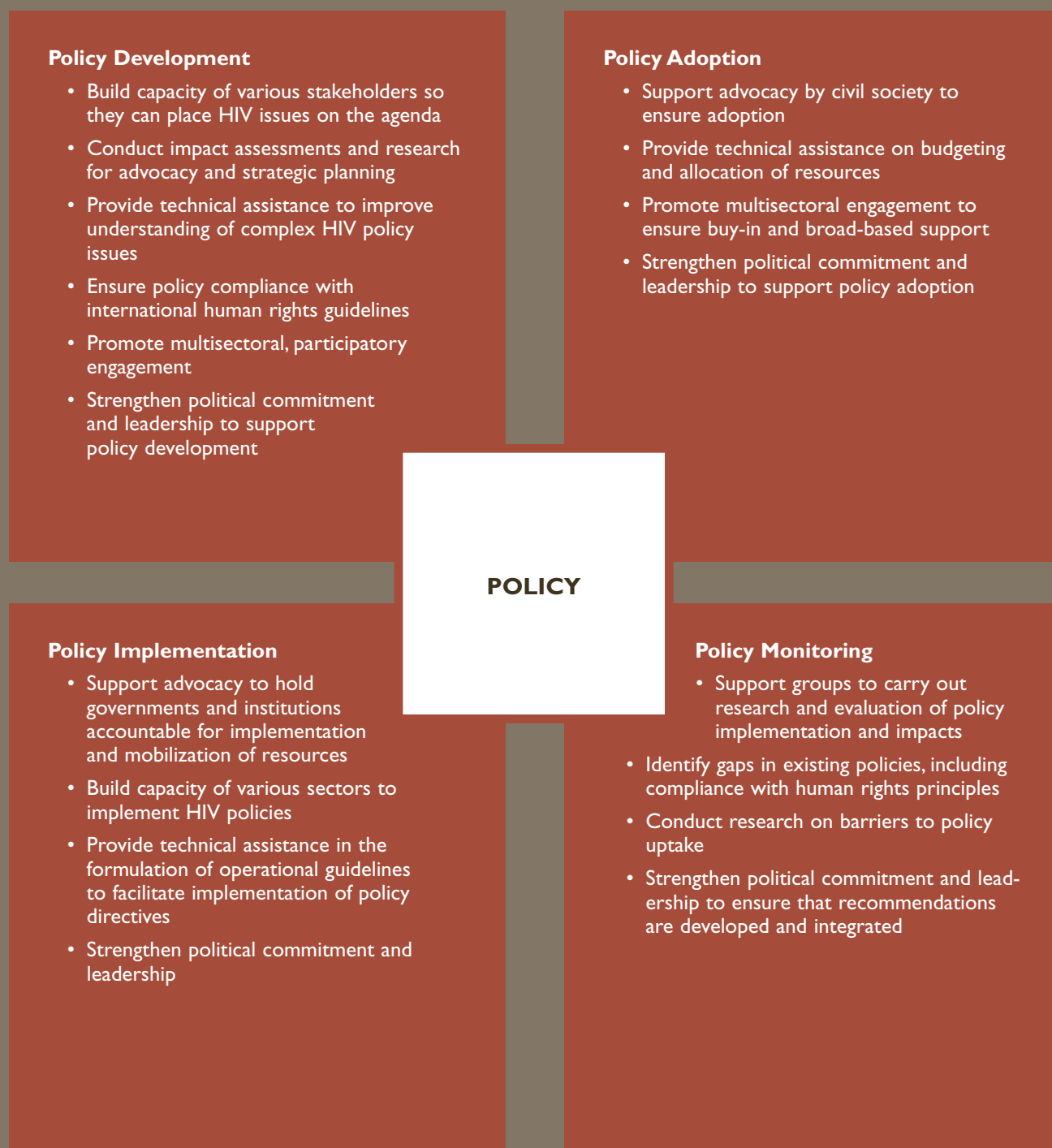
- Enumerate the rights, roles, and responsibilities for various actors;
- Guide resource allocation, mobilization, and use; and
- Provide the mechanisms for monitoring and evaluating progress toward achieving goals and objectives.

There are many reasons why policies are important for HIV work in particular. The nature of the pandemic itself—how its effects are felt across all sectors and groups—demands a multi-sectoral response and policies are integral to coordinating these activities. Effective resource allocation and mobilization points to the need for strategic plans and budgets that are well thought out. As breakthroughs occur, countries need to update and modify their policy and legal frameworks to guide new approaches and services. Given the stigma and discrimination associated with HIV, policies and strong politi-

cal commitment can be the first steps in challenging the silence that surrounds the pandemic. Furthermore, laws and policies are essential for protecting the rights of vulnerable groups, such as women and orphans and vulnerable children. Finally, operational guidelines are needed to ensure smooth implementation of prevention, treatment, and care services.

POLICY's overarching strategic objective is to promote policies and plans that sustain access to high-quality reproductive healthcare, including HIV programs. Policies are most effective when they are developed in a participatory manner, because involvement of various stakeholders promotes ownership, ensures greater likelihood of implementation, and takes into account the needs and assets of different groups. As shown in Figure 2, the project's approach appreciates that the "policy environment" encompasses not only the drafting of

FIGURE 2. HOW THE POLICY PROJECT SUPPORTS VARIOUS ASPECTS OF THE HIV POLICYMAKING PROCESS



2

COLLABORATION ENHANCES MALAWI'S NATIONAL HIV/AIDS POLICY

On November 10, 2003, the President and Cabinet of Malawi adopted the country's first National HIV/AIDS Policy, which was the culmination of an intensive 18-month participatory policy process. POLICY played a major role in seeing the policy through to its approval by facilitating the policy process and providing technical assistance to help stakeholders better understand complex HIV issues. Building on its existing relationships with the government, civil society, and networks for people living with HIV, POLICY was able to increase broad-based participation in the policy's development.

"The government was welcoming of our role in the national policy process," recalls George Kampango of the Malawi Network for People Living with HIV/AIDS (MANET+).

POLICY had provided assistance to MANET+ to conduct research on stigma and discrimination in Malawi. As POLICY worked with both the National AIDS Council and MANET+, the project was able to facilitate the network's inclusion on the Multisectoral Policy Advisory Council. MANET+ presented its stigma and discrimination findings to fellow council members and reviewed drafts of the proposed policy. Several MANET+ recommendations were included in the final policy.

"With the national policy, implementation will take time, but people are starting to see that they should stand by those guidelines," Kampango says.

specific policies and guidelines, but also includes facilitating participation in the process and ensuring the mechanisms to devise, implement, and monitor those policies and guidelines.³ Throughout the policy process, POLICY seeks to build capacity of the various stakeholders, from government officials to NGOs and businesses to people living with HIV and vulnerable groups (for an example from Malawi, see "Policy | People | Practice 2"). The project provides stakeholders with the training and tools to identify policy issues, conduct research and situational analyses, advocate for policy change, plan responses and mobilize resources, and monitor and evaluate policies and their implementation.

3. For more on the policy process, see Stover and Johnston (1999), Cross et al. (2001), and Hardee et al. (2004).

SUPPORTING NATIONAL POLICY DEVELOPMENT

POLICY's work has resulted in the development and adoption of 33 national or regional HIV policies, strategies, and strategic plans in 12 countries and for the REDSO/ESA region; subnational strategic plans in three countries; and various sectoral policies (on issues such as

gender, armed forces, and orphans and vulnerable children) in eight countries and for the Southern Africa region. The examples below highlight our work with national and subnational governments as well as our efforts to broaden participation in national policymaking processes. Box 3 describes POLICY's role in monitoring the

HIV policy environment at global and national levels, which helps policymakers and program planners identify gaps in policy responses and assess the impact of policies and programs. (Our policy achievements within other sectors [e.g., faith-based organizations, workplaces] are discussed in the sections to follow.)

NATIONAL POLICIES

| Level | Year | Focus Area | POLICY Role |
|-----------------|------|------------------------------------|---|
| Government-wide | 2003 | National policy reform (Nigeria) | Provided technical assistance to the National Action Committee on AIDS leading to the development and passage of Nigeria's revised National HIV/AIDS Policy |
| | 2003 | National policy (Malawi) | Led a participatory process to draft the country's first-ever National HIV/AIDS Policy, including technical assistance to national government and civil society stakeholders; the policy was adopted in October 2003 |
| | 2004 | National policy (Ghana) | Facilitated identification of issues and formation of tasks teams that drafted Ghana's National HIV/AIDS and STI Policy, approved in August 2004 |
| Sectoral | 2001 | Condom policy and strategy (Kenya) | Promoted policy dialogue leading to adoption of Kenya's National Condom Policy and Strategy for 2001–2005, which ensured commodities for family planning and HIV prevention |
| | 2004 | Adolescent health (Guatemala) | Provided technical assistance to the Ministry of Health to devise a National Adolescent Program outlined in the National Adolescent Policy that covers HIV prevention, reproductive health, and gender equity |
| | 2004 | Access to drugs (Peru) | Supported the advocacy and policy dialogue efforts of the NGO, Acción Internacional para la Salud, leading to passage of the National Drug Policy that seeks to expand access to high-quality, affordable essential medicines primarily for people living with HIV and chronic diseases |

BOX 3

MONITORING THE HIV POLICY ENVIRONMENT

POLICY has designed and applied assessment tools for monitoring the HIV policy environment. These assessments have become a critical resource for informing both national and global strategic planning. Such information is essential for ensuring progress toward stated goals (e.g., as outlined in UNGASS or the President's Emergency Plan) and for identifying program areas requiring greater commitment and resources.

The **AIDS Policy Environment Score (APES)** measures the degree to which a country's policy environment supports efforts to prevent the spread of HIV and sexually transmitted infections (STIs); provide quality care; ensure the rights of people living with HIV; and mitigate the negative impacts of HIV on individuals, families, communities, and society. The APES is based on the perceptions of knowledgeable respondents concerning the HIV policy environment through their rating of a series of statements in seven categories: political support, policy formulation, organizational structure, program resources, evaluation and research, legal and regulatory environment, and program components. It is designed to reflect both the current level of support and changes that take place over a one- to three-year period as a result of policy activities. It may also be useful for assessing areas where policy change is most needed. POLICY has used the APES in countries such as Benin, Kenya, Malawi, Mexico, and Tanzania.

POLICY has conducted two rounds of both the **AIDS Program Effort Index (API)** and the **coverage survey** and will repeat both in late 2005. The API measures national program effort across

10 categories in 50 countries. It produces a national profile showing where effort is strongest and weakest and also measures progress from the previous round. Several USAID country missions and two regional programs⁴ use the API as a high-level indicator to track progress on improving the policy environment for HIV. At the global level, UNAIDS uses the API as part of its UNGASS reporting. UNAIDS incorporated many items from the API into its National Composite Policy Index (the official UNGASS indicator for policy) and has asked POLICY to repeat the API in 2005 so that it can be included in the UNGASS Progress Report to be sent to the Secretary General in early 2006.

The coverage survey measures the number of people receiving key HIV prevention, treatment, and care services in 70 countries. This survey is a collaborative effort of the POLICY Project, USAID, UNAIDS, UNICEF, and WHO. It uses local consultants to collect service statistics and organizes national consensus workshops to review the findings. The data are aggregated by region and globally to produce a picture of current coverage and progress in the last two years. The 2004 report was released at a press conference organized by UNAIDS at the XV International AIDS Conference in Bangkok (POLICY et al., 2004). It has been a key source of information for efforts to gauge progress since 2001 and to estimate the resources required to expand coverage to all those in need. For example, while the estimated number of VCT clients doubled from 2001 to 2003, only 0.2 percent of adults use VCT services. This is well below the coverage needed to avert a significant number of future infections.

4. USAID's Guatemala-Central American Program and Regional Development Mission/Asia.

IMPROVING STRATEGIC ACTION PLANS

The UNGASS Declaration of Commitment on HIV/AIDS called on national governments to “ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms ...” by 2003 (UNGASS, 2001, p. 15).

Strategies and workplans outline the specific activities the government will take, in collaboration with partners, to achieve the goals and objectives outlined in policies. Strategic plans and budget allocations help ensure the implementation mechanisms and outline roles and responsibilities to facilitate putting policies into practice. POLICY has

worked with various national governments, departments, and subnational units to devise strategic action plans that facilitate implementation of policy directives. (“Policy | People | Practice 3” documents the project’s approach to strengthening the enabling policy environment in Ukraine.)

STRATEGIC PLANS

| Level | Year | Focus Area | POLICY Role |
|---------------------------|------|---|--|
| National | 2001 | Strategic action plan (Nigeria) | Assisted in drafting and facilitating stakeholder support for implementation of the national HIV/AIDS Emergency Action Plan (HEAP)—a three-year national strategy that identifies a budget and key interventions |
| | 2004 | Strategic action plan (Vietnam) | Coordinated multisectoral involvement in the policy process resulting in the new National Strategy for HIV/AIDS Control Until 2010 with a Vision until 2020 |
| | 2004 | Strategic action plan (Ukraine) | Provided technical assistance to design the National Program on Prevention of HIV Infection and Providing Care and Treatment for People Living with HIV for the Period 2004–2008 |
| Departmental/ Sectoral | 2003 | Health sector reform (Haiti) | Gathered data, facilitated stakeholder meetings, and prepared the draft of Haiti’s National Strategic Plan for Health Sector Reform, which is designed to improve health services, including those relating to HIV and FP/RH |
| | 2003 | Mobilization of parliamentarians (Uganda) | Facilitated the planning process for the three-year strategic plan and one-year workplan for the Parliamentarians Standing Committee on HIV/AIDS |
| Subnational | 2002 | State-level action plan (Nigeria) | Continued support to implement the national HEAP by assisting the Oyo State Action Committee on AIDS to finalize a three-year HIV action plan |
| | 2004 | District action plan (Nepal) | Provided technical assistance and awarded a small grant to the Bhaktapur District Development Committee to devise a five-year strategic plan |

3

STRENGTHENING THE POLICY RESPONSE TO HIV IN UKRAINE

Reflecting on the country's HIV policy environment, Dr. Nadiya Zhyhka, head of the obstetric-gynecologic service in the Ministry of Health of Ukraine, explained, "It turned out that independent Ukraine had virtually no documents that regulate medical activities. Everybody used orders issued in Soviet times. We started to work on such documents, but we lacked information. We had to literally pick up crumbs of it."

With commitment from government leaders at national and oblast levels and involvement of NGOs and people living with HIV, the policy response in Ukraine is starting to change. POLICY's assistance has helped facilitate the following:

- Development of the PMTCT strategy for 2005–2011 and Budget Requirement Analysis submitted to the Cabinet of Ministers for approval.
- Drafting of the National VCT protocol, approved by the Ministry of Health in June 2005, that outlines goals, objectives, and principles of VCT service provision.
- Preparation of a strategic workplan and budget for a GFATM-funded project coordinated by the International HIV/AIDS Alliance, leading the Global Fund to allocate US\$17,000 in the 2005–2006 budget for HIV test kits for the most at-risk populations.
- Establishment of four oblast-level Multisectoral Working Groups with the mission of improving the planning, management, and monitoring and evaluation of oblast HIV programs.
- Formation of an HIV/AIDS NGO coalition and increased participation of NGOs and people living with HIV in national policymaking bodies, such as the National Coordination Council to Prevent the Spread of HIV/AIDS; importantly, the Cabinet of Ministers adopted a resolution requiring the council to include an HIV-positive person as one of the two deputies for the council.
- Development of political commitment-related components of the National Program on Prevention of HIV Infection and Providing Care and Treatment to People Living with HIV/AIDS for the Period of 2004–2008 and Decree Number 264, "On Approving the Concept of Government Strategy to Prevent the Spread of HIV Infection/AIDS for the period till 2011."

ESTABLISHING PROGRAM GUIDELINES, REDUCING OPERATIONAL BARRIERS

A key aspect of POLICY's work is to link strategic planning and policy development to the implementation of programs, which is done in part through operational guidelines. As the name suggests, operational guidelines are the laws, regulations, and codes that guide implementation of all aspects of how programs and services are provided. Guidelines must consider issues such as how many staff are required in various settings; who can provide what level of medical care; what are the minimum standards of care; and what are the costs for services. In many cases, "program deficiencies, such as a lack of trained service providers and other resources, can be traced to operational policies that are inadequate, inappropriate, or outdated" (Cross et al., 2001, p. v). When drafted or modified appropriately, operational policies can help enhance the quality of HIV programs by making more efficient use of existing resources.



PHOTO CREDIT: PABLO MAGAZ

Collaboration meeting with the Central America HIV/AIDS Prevention Project (PASCA) and Acción SIDA in Honduras.

PROGRAM GUIDELINES / REDUCING OPERATIONAL BARRIERS

| Level | Year | Focus Area | POLICY Role |
|---------------------------|------|--|---|
| National | 2002 | Care and treatment (Haiti) | Assisted in preparing "Norms and Operational Policies for Care of People Affected by HIV/AIDS" for approval by Ministry of Health, which provides guidance on care, treatment, and ARVs |
| | 2003 | VCT (Ghana) | Collaborated in devising National Guidelines for the Development and Implementation of HIV Voluntary Counseling and Testing, that sets minimum acceptable standards for establishing VCT clinics, including staff qualifications, training, and mandatory pre- and post-test counseling |
| | 2004 | ARV provision (Malawi) | Participated in a task force and equity strategy drafting team that helped formulate the development of Malawi's five-year, free ARV program |
| Departmental/ Sectoral | 2002 | Public sector (South Africa) | Conducted research to inform the Department of Public Service and Administration's (DPSA) Minimum Standards on HIV/AIDS, which provide guidelines on managing HIV in the public sector; DPSA is South Africa's single largest employer, encompassing 1.1 million public servants |
| | 2004 | Positive support groups (South Africa) | Worked with 20 national stakeholder groups to devise the National Health Department's Guidelines for Support Groups for People Living with and/or Affected by HIV and AIDS, which are intended to guide the public health sector and serve as a resource for community-based groups |
| Subnational | 2003 | State-level health care facilities (Nigeria) | Assisted in devising the Enugu State HIV/AIDS Policy for Healthcare facilities, which includes operational guidelines to reduce stigma and discrimination |



LEADERSHIP AND ADVOCACY

PHOTO CREDIT: GETTY IMAGES

Faith-based leaders are increasingly speaking out against HIV-related stigma and encouraging compassionate care for those affected by the pandemic.



LEADERSHIP AND ADVOCACY





PHOTO CREDIT: PALANI MOHAN

POLICY BRIEF: LEADERSHIP AND ADVOCACY

- HIV touches on sensitive social issues, such as sex and sexuality, gender and economic inequalities, and norms governing individual behaviors—leaders are essential, therefore, for breaking the silence on these issues and promoting open community dialogue.
- The pandemic requires a multisectoral response and leaders must be strengthened in all sectors, including the government, faith-based organizations, civil society groups, and the private sector.
- People living with HIV and members of vulnerable groups must play a leading role in the response; meaningful involvement not only builds capacity of vulnerable groups but also improves HIV policies and programs.
- POLICY strengthens the capacity of policy champions from across sectors so they can advocate for locally determined policies and programs. Advocacy moves beyond simply raising awareness to promoting concrete strategies and actions for addressing priority issues. It can be used to encourage leadership, commitment, and broad-based support for HIV policies and programs.

“If leaders talk, the community talks. Breaking the silence is the first step in the fight against the epidemic.”

—Chandrababu Naidu

former Chief Minister, Andhra Pradesh, India

(APLF et al., 2004, p. 21)

Strong leadership at all levels and from across sectors is needed to catalyze responses to the HIV pandemic. Leaders play important roles throughout the response, for example: breaking the silence surrounding HIV; keeping HIV on the national agenda; guiding policy and legal reforms; encouraging broad-based support and buy-in for program implementation; making decisions on resource allocation and mobilization; and ensuring the wherewithal to support a sustained response. Countries that have demonstrated strong leadership are the ones that have had greater success in addressing the pandemic.

HIV is a particularly complex societal challenge that raises sensitive issues regarding sex and sexuality, gender and economic inequalities, and social norms governing individual behaviors. Given this, inspiring dedicated, authentic leadership remains one of the greatest

challenges in the HIV response. Leaders—whether from government, civil society, vulnerable groups, or the private sector—may be stifled by lack of skills and capacity or by stigma and factors such as gender norms that not only increase vulnerability to HIV but also limit the ability of different groups to participate in the policy process. When leaders speak out on HIV, however, it can help give those most affected by the pandemic the courage to come forward and it can facilitate community dialogue on issues surrounding HIV—and ending the silence is critical for averting future infections and ensuring high-quality treatment and care.

POLICY’s approach to strengthening leadership recognizes that leaders must come from all sectors. Three groups that POLICY has focused attention on are government leaders, faith-based organizations, and people living with HIV and vul-

nerable groups. In terms of the HIV response, these are groups that are crucial for changing community attitudes, marshalling support and resources for policies and programs, and improving understanding of the pandemic and its impact on those most affected. Importantly, people living with HIV and vulnerable groups must play a leading role in the response; meaningful involvement not only builds capacity of vulnerable groups but also improves HIV policies and programs.

POLICY builds the capacity of policy champions within public, faith-based, civil society, and private sectors who can advocate for policy change, giving them the skills they need to support implementation of locally-determined policies and programs. Advocacy involves targeted actions directed at key decisionmakers to facilitate policy dialogue and change regarding specific issues. Advocacy is a tool that can

be used to encourage strong leadership, commitment, and broad-based support. Advocacy moves beyond simply raising awareness to promoting concrete strategies and actions for addressing priority issues. This approach is essential for ensuring that policies are adopted and implemented.

STRENGTHENING GOVERNMENT LEADERSHIP AND POLITICAL COMMITMENT

Strong leadership from high-level government leaders has

inspired individuals at other levels of the public sector and society to formulate HIV policies and implement programs. POLICY provides technical assistance to high-level officials, including strengthening policy and planning skills, improving understanding of the impact of HIV in the local context, facilitating discussions and networking among leaders, and addressing complex HIV issues. With this support and improved understanding, many government leaders have publicly acknowledged the gravity of

HIV and the importance of addressing the pandemic. For example, Zambia's Deputy Minister of Labor and Social Security issued a statement of support for HIV-positive workers' rights, opening the door for changes in workplace policy and publicly affirming the rights of those living with HIV. In Zambia and elsewhere, such high-level political commitment has helped place and keep HIV issues, increased resource allocation, and effective interventions as priorities at national, regional, and local levels.

GOVERNMENT

| Level | Year | Department/Group | POLICY Role |
|-------------------------------------|------|--|--|
| Government and High-level Officials | 2001 | Parliamentarians (Tanzania) | Supported formation of the Tanzania Parliamentary AIDS Coalition, with participation from nearly one-third of the 280 members of Parliament, including the Speaker, Deputy Speaker, and Prime Minister |
| | 2003 | Ministry of Labor and Social Security (Zambia) | Advocated for the rights of workers living with HIV, resulting in a statement of support by the Deputy Minister of Labor and Social Security for HIV-positive workers' rights that also discouraged employers from practicing stigma and discrimination |
| | 2004 | Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF) | Provided technical assistance for designing APLF's monitoring and evaluation framework; supported development of "ACT Now," a leadership and advocacy publication targeting leaders to increase understanding of the HIV pandemic in the region (APLF et al., 2004); and assisted in training of media leaders |

“I had never been a leader in class or college, but I have become a leader amongst HIV-positive women in Nepal.”

—Chhiring Doka Sherpa
President, Sneha Samaj



BUILDING LEADERSHIP CAPACITY OF PEOPLE LIVING WITH HIV AND VULNERABLE POPULATIONS

As people living with HIV and vulnerable populations are the experts when it comes to understanding what programs and approaches are needed by those most affected by the pandemic, these groups must be at the center of the HIV response. Meaningful involvement not only improves policy and program responses, it also empowers vulnerable groups, which reduces vulnerability and improves life skills. For example, an HIV-positive person who can openly, confidently participate in national policy dialogue is much more likely to seek and adhere to treatment than a person who fears disclosure of his or her HIV status.

However, while the past five years witnessed increased support for the GIPA Principle, practice has often lagged far behind.

POLICY made a concerted effort to make meaningful involvement a reality, often through capacity building and leadership approaches designed by and for HIV-positive people and those most affected (see “Policy | People | Practice 4”). Capacity building has included leadership development, public speaking, advocacy and policy skills, specific technical areas (e.g., treatment literacy, stigma reduction), participatory assessment approaches, English language skills, and program management. As a central feature, POLICY assisted in the creation and strengthening of networks of people living with

HIV to create mechanisms for the exchange of experiences, lessons learned, and strategies at local, national, regional, and international levels. As a result, those most affected by HIV are increasingly playing leadership roles in advocacy and policy dialogue around HIV prevention, treatment, and care issues. In Nepal, for example, the GFATM Country Coordinating Mechanism (CCM) now has two HIV-positive members, including the first woman, who is a member of Sneha Samaj—a support group that was created with assistance from POLICY and is the first group in the country for women and children living with and affected by HIV. (For an example of POLICY’s emerging approach for mobilizing vulnerable populations for sustained leadership, please see Box 4.)



PHOTO CREDIT: LAURETTE CUCUZZA

Advocacy skills workshop for the National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU) held in Kampala, January 17–21, 2005.

PEOPLE LIVING WITH HIV AND VULNERABLE GROUPS

| Level | Year | Group | POLICY Role |
|---|-----------|--|--|
| People Living with HIV and Vulnerable Groups | 2003 | Asia-Pacific Network of People Living with HIV/AIDS (APN+) | Assisted in building organizational capacity to position APN+ as an effective regional advocacy network for people living with HIV, and collaborated in providing technical assistance to HIV-positive networks in Cambodia, China, and Lao Peoples' Democratic Republic |
| | 2004 | Sneha Samaj (Nepal) | Assisted HIV-positive women to form the first organization for women and children living with and affected by HIV in Nepal |
| | 2004 | Coalición de Organizaciones y Grupos Gay y Lesbianas de Honduras (COGAYLESH) | Strengthened communication and advocacy skills of COGAYLESH members and supported development of a training tool for working with law enforcement and military officials to reduce stigma and discrimination; three MSM organizations were officially recognized by the government |
| | 2004–2005 | International Community of Women Living with HIV/AIDS (South Africa and Swaziland) | Collaborated in implementing a rapid-assessment and HIV advocacy curriculum to promote HIV-positive women's reproductive health and to outline a women's treatment advocacy agenda |

4

STRENGTHENING INVOLVEMENT OF PEOPLE LIVING WITH HIV IN THE GLOBAL FUND COUNTRY COORDINATING MECHANISMS

A central tenet of international initiatives, such as GFATM and the President's Emergency Plan, is to involve those most affected by the pandemic in policy and program responses. Putting the principle of greater involvement into practice, however, often remains a challenge. While the GFATM Country Coordinating Mechanisms (CCMs), for example, mandate inclusion of people living with HIV, such participation is often limited or token. A 2003 assessment led by the Global Network of People Living with HIV/AIDS (GNP+) and POLICY, and funded by USAID and the German Council for Sustainable Development (GTZ), found shortcomings in the operation of the CCMs. HIV-positive representatives, drawn from 17 countries in all, remarked:

"I stay quiet and sign what has been decided without understanding why it has been decided as discussions and decisions are not in my language."

"I feel my voice is not heard on the CCM."

"I do not know what selection process they followed. I received a letter saying you have been selected to serve on the CCM board as a PLHIV representative." (Quoted in GNP+ et al., 2004a, p. 13.)

As a next step, GNP+ and POLICY facilitated consultation meetings with people living with HIV to review the assessment findings. Participants agreed that there was a need for a handbook for people living with HIV and a set of guidelines for the GFATM and CCMs to strengthen involvement of the HIV-positive community. POLICY, GNP+, GTZ, and USAID collaborated to create these tools in 2004, a process that involved more than 400 HIV-positive people in about 30 countries.

More than 1,000 copies of the handbook, *Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in CCMs* (GNP+ et al., 2004a), have been distributed to CCMs and networks of people living with HIV. In addition, 5,000 copies of the "Guidelines for Improving CCMs through Greater PLHIV Involvement" (GNP+ et al., 2004b) have been disseminated. The tools were printed in English, French, Spanish, Russian, Thai, Vietnamese, and Nepali, and translations into Chinese, Hindi, Kiswahili, and Portuguese are under consideration. GFATM approved the guidelines in November 2004 and revised its guidance for CCMs. Countries such as Malawi, Nepal, Ukraine, and Vietnam are using the guidelines and have already noted changes in the way the CCMs operate.



BOX 4

THE NEXT GENERATION: MOBILIZING VULNERABLE COMMUNITIES FOR SUSTAINED LEADERSHIP

While strong, visible leaders are crucial to a dynamic response, sustainable leadership needs to be anchored in and accountable to the organizations, networks, and communities of those they represent. POLICY initiated efforts to mobilize communities most affected by HIV to strengthen and expand the community base needed to support representative community leadership.

A key component of this approach is increasing the capacity of leaders from various community groups—women, people living with HIV, and other marginalized groups—to undertake activities that maximize their constituency's participation in the development or implementation of policies that directly affect them. For example, peer-to-peer mobilization has included initiatives to increase knowledge of key technical information, such as treatment literacy, and to develop community support and organizational structures. Working to build peer-to-peer education and mobilization has allowed these leaders to refine their own organizational and leadership capabilities and bring communities together in new and invigorating ways.

With a shared sense of purpose and motivation, strengthened community support and mobilization have been key elements in helping groups move forward and engage policymakers, often for the first time. The following activities exemplify this movement:

- In **Kenya**, POLICY collaborated with the Kenya Human Rights Commission and the Jaramogi Oginga Odinga Foundation to address women's property ownership and inheritance rights through an advocacy approach focused on identifying community and cultural structures that impede women's property rights.

POLICY and other organizers provided analytical tools and facilitated analysis among a diverse group of community and national NGOs to assess how to secure these rights. A key strategy was to mobilize women and traditional leaders. That effort culminated in the leader of the Council of Elders mandating outreach advocacy activities and action plans to eliminate violations of women's property rights. Local women's groups and HIV service organizations have continued to develop peer education skills related to women's rights that foster meaningful and sustainable changes.

- In **Nepal**, through a process of strengthening leadership among those most affected, the POLICY team worked with local community organizations and support groups to identify, bring together, and nurture a network of recovering IDUs. The network, Recovering Nepal (RN), has proven that vulnerable groups can mobilize and become involved in policy dialogue at all levels. In only 18 months, RN provided recovering drug users with information and strengthened public speaking skills using a leadership curriculum designed by and for IDUs. RN has initiated IDU-led information and dialogue sessions with local stakeholders, including police, healthcare professionals, and media on the links among HIV, injection drug use, and stigma and discrimination. Activities have resulted in increased media coverage through radio, newspapers, and TV. In addition to success in mobilizing peer constituencies, RN has also engaged in national policy dialogue, influencing changes in national substitution therapy guidelines and donor policies on eligibility for proposals. RN also became an officially registered NGO in Nepal.

“[W]e have learned that ‘No one should die alone, no one should care alone.’ This view is supported by the uniquely African concept of ubuntu. Ubuntu affirms the interdependence of humanity. It teaches that I am only a person through other people.”

—The Most Reverend Njongonkulu Ndungane
Archbishop of Cape Town, Metropolitan of Southern Africa,
Anglican Communion Church Province of Southern Africa



PHOTO CREDIT: COURTESY OF POLICY/SOUTH AFRICA

MOBILIZING RELIGIOUS AND COMMUNITY LEADERS

Traditional leaders, faith-based organizations, and community groups are well-positioned to foster transformation of stigmatizing attitudes, facilitate open dialogue in support of HIV prevention efforts, and mobilize resources to provide care and support for those affected. POLICY has provided technical assistance to religious and community leaders, including those

from Buddhist, Christian, and Muslim faiths. A key aspect of this approach has been to help community- and faith-based leaders explore how religious and community values are integral to a compassionate response to HIV and those most affected. POLICY has worked with community and faith-based leaders to reach out to their communities to support people living with HIV. This support includes

preparing formal statements, strategic documents, and action plans designed to reduce stigma and discrimination and provide care and support (for an example, see “Policy | People | Practice 5”). As a result of such support, more communities of faith are now committed to mobilizing and coordinating scarce resources and have affirmed that their organizations fundamentally embrace the dignity and humanity of all those living with and affected by HIV.

RELIGIOUS AND COMMUNITY LEADERS

| Level | Year | Group | POLICY Role |
|---------------------------------|-----------|---|--|
| Religious and Community Leaders | 2002–2003 | Anglican Communion Church Province of Southern Africa | Facilitated planning sessions for all-Africa Anglican HIV Conference and assisted in creating a planning guide for the Anglican Communion HIV/AIDS Strategic Framework, which resulted in the Anglican Church’s first international HIV policy statement |
| | 2003 | Traditional religious leaders (Haiti) | Provided financial technical assistance in organizing the 20th International Memorial for AIDS; it marked the first time that traditional religious leaders participated in disseminating messages about HIV |
| | 2004 | HIV-positive religious leaders and allies (Kenya) | Facilitated formation of the Kenya Network of Religious Leaders Infected and Affected by HIV/AIDS, which includes representatives from 20 denominations |
| | 2004–2005 | Alliance of Religious Leaders on HIV/AIDS (Mali) | Facilitated dialogue between Christian and Islamic leaders, resulting in the creation of the Alliance; provided technical support to the West and Central Africa Caravan of religious leaders on combating HIV |

5

PUTTING HIV ON THE ANGLICAN MAP: THE STRATEGIC PLANNING PROCESS

POLICY's work with communities of faith is exemplified by its collaboration with the Anglican Communion's Church of the Province of Southern Africa (CPSA), which is led by the Most Reverend Njongonkulu Ndungane, Archbishop of Cape Town, Metropolitan of Southern Africa. In 2001, POLICY initiated a strategic HIV planning process with CPSA that mobilized followers at both the provincial and diocese levels. The immediate result of the "All Africa Anglican Conference on HIV/AIDS"—convened in Boksburg, South Africa, and supported by POLICY—was the creation of a planning guide (Judge and Schaay, 2001) and articulation of a vision statement to guide the church's HIV response in the region. By mid-2002, more than 1,000 people had participated in local planning processes, resulting in 23 diocesan plans and completion of the overall strategic plan for the CPSA.

"For a process such as this to work, you can't have a small group that says, 'We're going to write this plan in our back room and then give it to everyone to implement.' It was such a significant gathering of people from across Africa that the conference felt as though it had the weight of the continent behind it and everyone was witness to the commitments being made," recalls Nikki Schaay, former POLICY/South Africa Country Director. "Having the full support of Archbishop Njongonkulu Ndungane was also very important. HIV/AIDS is his passion and he's been very proactive in putting HIV/AIDS on the Anglican map—both in South Africa and across the whole of the continent."

John Peterson, Secretary General of the Anglican Consultative Council, reflected on the groundbreaking nature of the planning process: "The statement that came out of Boksburg, 'We, the Anglican Communion across Africa, pledge ourselves to the promise that future generations will be born and live in a world free from

AIDS' gave the church the mandate it had been seeking and helped support the development of HIV/AIDS desks in each Anglican province in Africa."

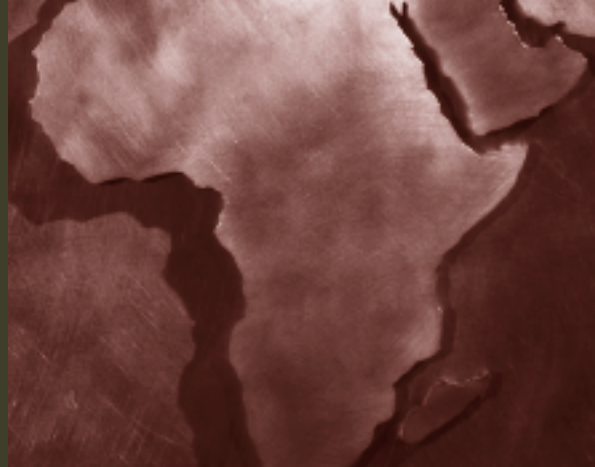
Some of the cascading effects of the planning process include:

- USAID/South Africa funded a program to train as many as 90,000 women across the Church Province in wellness management to assist those living with HIV.
- CPSA collaborated with governments in making sound HIV policies and has taken a public stand with others from civil society in holding governments accountable for treatment and care.
- POLICY/South Africa assisted CPSA to articulate workplace guidelines, leadership training, wellness management courses, and guidelines on supporting orphaned children.
- Strategic planning efforts based on the CPSA model are being initiated in 54 African nations under the leadership of the Council of Anglican Provinces in Africa.
- An "International Anglican AIDS Fund" has been created.
- The CPSA was asked by the Anglican Consultative Council and the Archbishop of Canterbury to assist the worldwide Anglican Communion in meeting its self-imposed requirement of having HIV strategic plans and implementation strategies in place by September 2005.

For more on the CPSA's strategic planning process, please see <http://www.aco.org/special/hivaids/index.htm>.

REGIONAL RETROSPECTIVE

AFRICA



POLICY commenced its HIV work in Africa in the mid-1990s, initially focusing on increasing governments' understanding of epidemic dynamics through the use of the AIDS Impact Model. Since then, the project's scope and activities have expanded dramatically and, in 2005, now include strengthening faith-based leadership, incorporating gender perspectives, and mobilizing people living with HIV. POLICY's HIV portfolio in Africa has also grown to comprise 13 country programs plus three multi-country regional programs.

IMPROVING NATIONAL AND REGIONAL GOVERNMENT RESPONSES

Much of POLICY's work in sub-Saharan Africa aims to improve national and regional government policies and plans by strengthening government leaders' understanding of epidemic dynamics and by promoting effective resource allocation. These efforts have resulted in the effective formulation of national policies, plans, and operational guidelines—in countries including Ghana, Kenya, Malawi, Nigeria, and South Africa—and of a regional plan for Eastern and Southern Africa. Resource mobilization and allocation has been improved in Kenya, Lesotho, and South Africa. The project has also developed a toolkit for building political commitment at national and subnational levels based on its experiences and lessons learned in Africa (available at <http://www.policyproject.com/pubs/toolkit.cfm>).

STRENGTHENING FAITH-BASED LEADERSHIP

POLICY works with various communities of faith to increase their leadership capacity in the fight against HIV. As a result of POLICY's assistance, the following religious groups have adopted HIV policies and plans: the Catholic Bishops' Conference in Nigeria, the Anglican Communion's Church Province of Southern Africa, the Anglican Church of Tanzania, the Inter-Religious Council of Uganda, the National Islamic Network for the Battle Against HIV/AIDS in Mali, and the Seventh Day Adventist East Africa Union. POLICY has also strengthened the organizational capacity of faith-based groups, including the National Muslim Council of Kenya Women's Network and the Kenya Network of Religious Leaders Infected and Affected by HIV/AIDS. With POLICY's support, religious leaders have helped to break the silence surrounding HIV. In Mali, for example, POLICY helped organize the 2002 HIV/AIDS Advocacy Day for Religious Leaders. During this event, the President of Mali addressed Islamic leaders, who later expressed public support for HIV initiatives.

INCORPORATING GENDER INTO HIV RESPONSES

In 2001, POLICY/Kenya co-founded, and has since co-led, the national Gender HIV/AIDS Technical Subcommittee of the National AIDS Control Committee. The subcommittee produced "Mainstreaming Gender into

the Kenya National HIV/AIDS Strategic Plan 2000–2005," which was integrated into the national HIV strategic plan in 2002. Also in Kenya, POLICY worked with NGOs to promote and protect women's inheritance and property rights at both the policy and grassroots levels. In provinces across South Africa, POLICY supported the "Men in Partnership" initiative, which sought to mobilize men in the HIV response. In Swaziland and South Africa, POLICY has collaborated with local groups to analyze and promote HIV-positive women's reproductive health.

MOBILIZING PEOPLE LIVING WITH HIV

In Africa, POLICY has supported eight national networks of people living with HIV, resulting in increased HIV-positive leadership, capacity, and participation in policymaking processes. Among the groups POLICY has worked with are the Malawi Network of People Living with HIV/AIDS, the Network of People Living with HIV/AIDS in Kenya, the Network of People Living with HIV/AIDS in Zambia, the Network of People Living with HIV/AIDS in Tanzania, and the Tanzania Network of People Living with HIV/AIDS. People living with HIV have also been key partners in POLICY's work in the region—for example, in collaborating on a South Africa project to design indicators to measure stigma and discrimination and to develop stigma mitigation approaches.

ASIA AND THE NEAR EAST

POLICY commenced its HIV work in the Asia and Near East region in 2001, and the program has since steadily grown. The portfolio now includes the Greater Mekong Regional program and country-level activities in Cambodia, India, Nepal, Vietnam, and the Southern China provinces of Yunnan and Guangxi. In 2005, POLICY initiated work in Egypt and Jordan, where HIV efforts remain nascent.

STRENGTHENING POLITICAL COMMITMENT AND LEADERSHIP

POLICY has been instrumental in strengthening leadership by supporting improved data advocacy and analysis. To achieve this result, the AIDS Impact Model was applied in Cambodia, China, the Lao People's Democratic Republic, and Vietnam and, in 2003, was followed by collaboration with the Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF). This collaboration has helped leaders speak out and speak to each other about the pandemic in the region in order to inspire strong leadership and take advantage of a window of opportunity to stop the spread of HIV before it expands even further in Asia and the Pacific. The resulting "Act Now" publication (APLF et al., 2004) has been translated into Bahasa Indonesia, Chinese, and Vietnamese to support high-level policy dialogue. In early 2005, POLICY collaborated with the Association of Southeast Asian Nations on projecting the socioeconomic impact of HIV in the 10 member nations, addressing HIV-related stigma and discrimination in the health sector, and assessing regional economies of scale for purchasing drugs and reagents. Since 2003,

POLICY has provided technical support to the Vietnamese government to revise the national HIV/AIDS ordinance, and as a result, the National Assembly agreed to upgrade the draft ordinance to a much higher legal status. In Jordan, POLICY is providing technical assistance to the National AIDS Committee to identify policy gaps and devise advocacy strategies that support the implementation of the proposed National Strategy for HIV/AIDS, 2005–2009.

INCREASING INVOLVEMENT OF PEOPLE LIVING WITH HIV

In Cambodia, POLICY collaborated with the Khmer HIV/AIDS NGO Alliance to support formation of the country's first national network of HIV-positive organizations, the Cambodian Network of People Living with HIV/AIDS (CPN+). In 2004, with POLICY support, people living with HIV in Vietnam established the first network of HIV-positive organizations in Ho Chi Minh City. POLICY's support was instrumental in selecting three HIV-positive representatives as members of Vietnam's CCM. In Nepal, POLICY facilitated the formation of Sneha Samaj, the country's first organization for women and children affected by HIV/AIDS. Regionally, POLICY has built the organizational capacity of the Asia-Pacific Network of People Living with HIV/AIDS (APN+). Together, POLICY and APN+ have worked to strengthen three HIV-positive organizations in the Mekong region: AIDS Care China-Yunnan Province, CPN+, and Lao Network of People Living with HIV/AIDS. In late 2005, POLICY will conduct a regional workshop in Egypt to facilitate forming the first HIV-positive

national and regional networks in the Near East.

IMPROVING INTEGRATED ANALYSIS AND ADVOCACY—THE A² MODEL

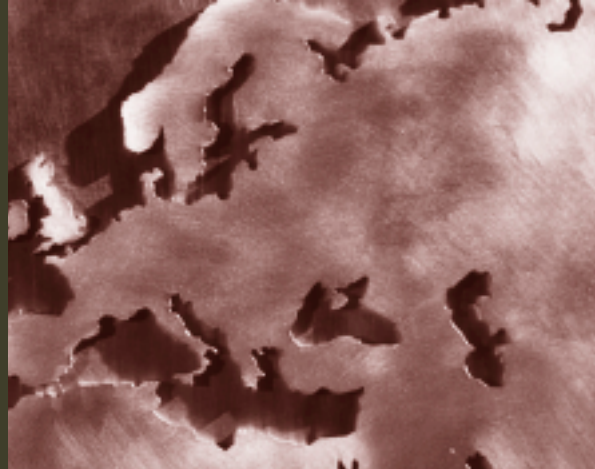
Launched in November 2004, A² (analysis and advocacy) is a joint regional project of POLICY, Family Health International, and the East-West Center. It is currently taking shape in Bangladesh, Thailand, Vietnam, and Yunnan and Guangxi Provinces in China. The project's objective is to develop a clear understanding of the HIV pandemic in Asia and to translate that understanding into effective national policies and appropriately targeted resources and programs. The project collects and analyzes local epidemiological, behavioral, response, and program costing data; determines optimum responses and resource requirements; and actively targets policymakers and donors with this information.

ENCOURAGING MULTISECTORAL ENGAGEMENT

POLICY has engaged a range of partners in the HIV policymaking process. They include faith-based organizations, such as Wat Norea in Cambodia; police forces in Nepal, which recently developed their own HIV strategy and training curriculum; human rights groups in Nepal; and several vulnerable groups. In 2005, POLICY assistance to the Catholic Bishops Conference of India facilitated the development and adoption of the Catholic Church HIV/AIDS Policy and Catholic Church Health Policy.

REGIONAL RETROSPECTIVE

EUROPE AND EURASIA



With the initiation of HIV policy work in Ukraine in September 2003, POLICY's HIV portfolio has extended to Europe and Eurasia. POLICY/Ukraine and its partners have been instrumental in raising awareness of the reproductive health needs of HIV-positive pregnant women as well as strengthening the capacity of NGOs and people living with HIV. (For more on POLICY's work in national policy development, please see "Policy | People | Practice 3" on page 26).

ADVOCATING FOR HIV-POSITIVE WOMEN'S REPRODUCTIVE HEALTH

HIV-positive women face many challenges when accessing reproductive healthcare in Ukraine. In response, POLICY designed an advocacy framework to help remove the related operational policy barriers. Based on the framework, the project supported a community advisory board that included people living with HIV and applied a human rights approach. The initiative included

- An orientation workshop to educate partners about human rights;

- A qualitative survey with HIV-positive women and providers to document the barriers that HIV-positive women face in accessing reproductive healthcare;
- A targeted review of Ukrainian laws; and
- Policy dialogue and advocacy.

The efforts were highly successful, as the Ministry of Health Working Group used data from two POLICY reports to inform preparation of a new PMTCT program for 2005–2008 and a National VCT Protocol.

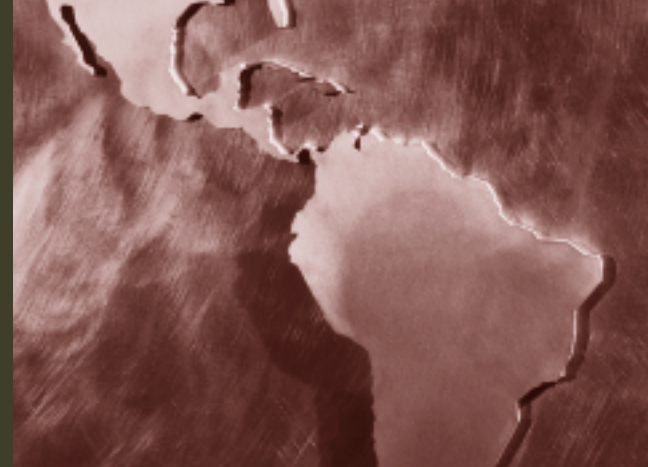
INCREASING INVOLVEMENT OF NGOS AND PEOPLE LIVING WITH HIV IN NATIONAL POLICYMAKING BODIES

By providing technical and financial assistance, POLICY has strengthened and broadened the participation of NGOs working on HIV issues. This support has included helping to form the Coalition of HIV Service NGOs in Ukraine, which has since focused on increasing the capacity of the GFATM Country Coordinating Mechanism (CCM) to

involve people living with HIV and to provide guidance on how CCMs can be improved. In February 2005, the Ukrainian Network of Positive People used two resources that POLICY helped produce—the handbook *Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating Mechanisms* (GNP+ et al., 2004a) and "Guidelines for Improving CCMs through Greater PLHIV Involvement" (GNP+ et al., 2004b). The network was successful in using the guidelines to advocate for a more inclusive, representative CCM structure. For example, the Cabinet of Ministers adopted a resolution to establish a National Coordination Council and stipulated that one of the council deputies must be a person living with HIV. The resolution also stipulated that different constituencies (e.g., HIV-positive people, NGOs, private sector) will select their own representatives on the national council and on each of the Oblast (regional) AIDS Coordination Councils.

REGIONAL RETROSPECTIVE

LATIN AMERICA AND THE CARIBBEAN



POLICY's HIV work in Latin America and the Caribbean began in Mexico in 1997 and in Haiti in 1999. In 2002, POLICY began work in Peru and Honduras. Over the past few years, Jamaica has received HIV funds for multisectoral youth activities and, in 2005, received funds for work to address stigma and discrimination.

REDUCING STIGMA AND DISCRIMINATION

In Mexico, POLICY and local partners have developed recommendations and guidelines for reducing internal stigma among people living with HIV and addressing discrimination within the healthcare sector, workplaces, and the media. In Honduras, after POLICY conducted two workshops on media advocacy, people living with HIV and media professionals came together to form the Alliance of Media Advocates. The alliance monitors media coverage of HIV issues and identifies opportunities to promote positive media portrayals of those affected by the epidemic. In Peru, in 2004, POLICY assisted Colectivo por la Vida in elaborating and implementing a proposal to modify Article 7 of the country's AIDS Law to increase its responsiveness to the needs and rights of HIV-positive people. The proposed legislative changes included anti-discrimination language. POLICY mobilized support for the proposal, resulting in approval for the modifications by the

Congressional Health Commission and Congress.

BUILDING CAPACITY OF VULNERABLE GROUPS

HIV activities have focused on the importance of vulnerable populations, such as MSM and youth, in HIV prevention and mitigation. POLICY assisted a regional group, the Asociación para la Salud Integral y Ciudadanía en América Latina y el Caribe, in designing tools and building local capacity among MSM to develop and implement advocacy campaigns to promote men's health for effective HIV prevention and care among MSM. In Honduras, POLICY helped to strengthen the communication and advocacy skills of COGAYLESH, a network of MSM groups. The network devised a national advocacy plan and has undertaken activities aimed at reducing stigma and discrimination. In 2004, COGAYLESH successfully advocated for three local MSM organizations, resulting in the government of Honduras formally recognizing and awarding them nonprofit status. In Jamaica, in 2003, POLICY worked closely with the National Center for Youth Development (NCYD) to update a policy that recognizes the large proportion of Jamaican youth vulnerable to HIV. The health component of the National Youth Policy stipulates the full implementa-

tion of the HIV/AIDS/STI National Plan of Action. The NCYD designed the youth policy as a multisectoral policy, highlighting youth at risk for HIV/STIs as a key target group for interventions.

INCREASING MULTISECTORAL ENGAGEMENT

POLICY has supported the formation of multisectoral citizens groups (MCGs) in Mexico in five states. The MCGs build coalitions between the public sector and NGOs, advocacy groups, and service providers and undertake participatory strategic planning processes. In 2002, oversight and technical support for the MCGs transferred from POLICY to the National Center for Prevention and Control of HIV/AIDS, which incorporated the MCG approach as part of the national HIV program. The MCGs have been recognized publicly by the most senior federal and state officials for their valuable contributions and the role they play in bringing the public sector and civil society together to address HIV issues. Multisectoral responses have also been central to POLICY's work in Haiti, where the project has supported the HIV policy dialogue and strategic planning efforts of faith-based organizations, labor unions, and community groups, such as the National Association of Scouts.

RESOURCES AND DATA FOR DECISIONMAKING

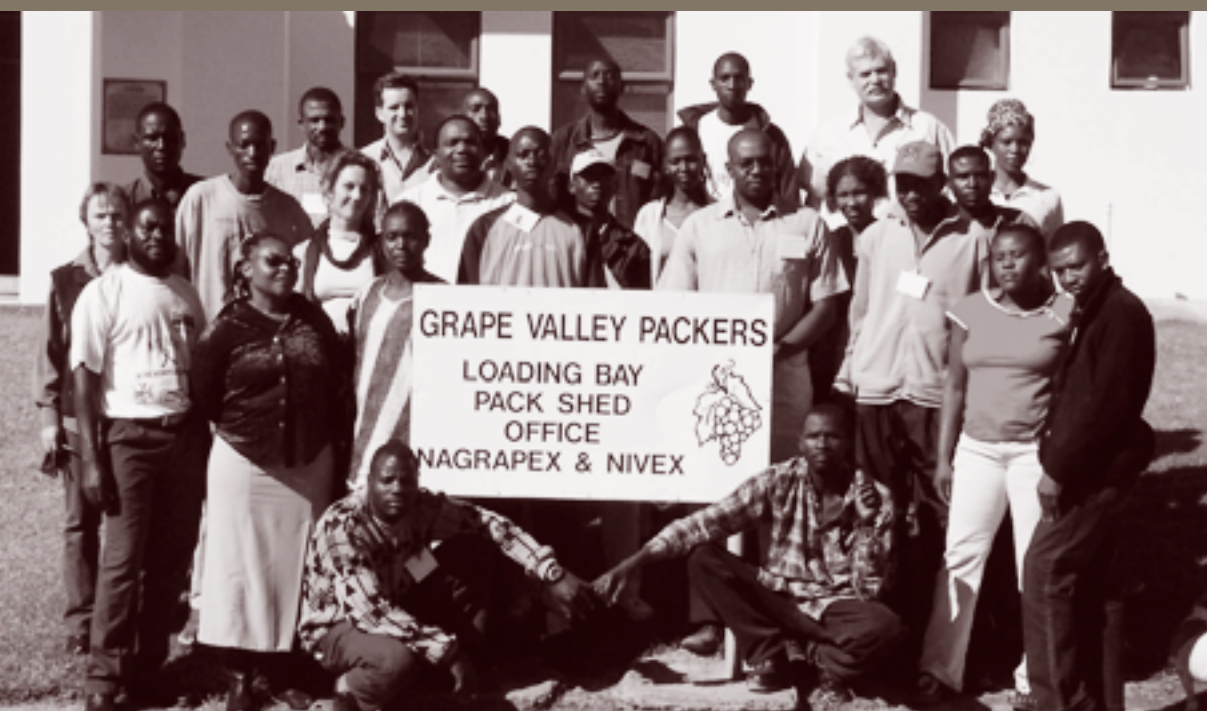


PHOTO CREDIT: COURTESY OF
GRAPE VALLEY PACKERS/NAMIBIA

Tools like the Workplace Policy Builder are helping businesses around the world improve their HIV policies and plans. Development of the software was funded by the U.S. Department of Labor with additional support from the POLICY Project.



RESOURCES AND DATA FOR DECISIONMAKING





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POLICY BRIEF: RESOURCES AND DATA FOR DECISIONMAKING

- Effective service delivery demands that wise decisions be made at the policy, planning, and budgeting stages; to do this, accurate data on the scope of the epidemic, the populations that are affected, the costs and coverage of services, and the likely impact of different strategies are needed to inform decisionmaking.
- Despite increased funding, resources for HIV remain inadequate—there is tremendous need for allocating and using resources efficiently and for avoiding waste and duplication of effort.
- The move to scale up programs brings with it the need to strengthen absorptive capacity to effectively take in and use additional resources, which requires strategic planning for infrastructure and human capacity development needs.
- User-friendly planning tools and models, such as those developed by POLICY, give planners the ability to analyze for themselves various scenarios and funding patterns to determine how best to allocate resources; these tools have encouraged multisectoral engagement in the planning process, improved in-country planning capacity, strengthened commitment, and increased resource mobilization.



PHOTO CREDIT: DOUG WILLIER

Models included in the SPECTRUM computer software package—such as the AIDS Impact Model and PMTCT Model—are used worldwide in policy and programmatic decisionmaking.

The global response to HIV has changed dramatically over the past five years, in terms of resources committed to fighting the disease and understanding of the complexities of the pandemic. In the field of HIV and economics, the primary focus was to define the economic impact of HIV rather than identify the potential ways in which new resources could be mobilized and applied (Forsythe and Rau, 1998). Similarly, little was known about the magnitude of the need for resources; preliminary work as early as 1996 indicated great uncertainty about the level of resources required (Broomberg et al., 1996). Policy and program planners also lacked data for improving responses, for example, data on the populations served by particular

interventions or the cost-effectiveness of different interventions.

Initiatives such as the President's Emergency Plan and GFATM have dramatically increased available resources for prevention, treatment, and care. Despite increased funding, resources for HIV remain inadequate—there is tremendous need for allocating and using resources efficiently and for avoiding waste and duplication of effort. The move to scale up programs also brings with it the need to strengthen absorptive capacity to effectively take in and use additional resources, which requires strategic planning for infrastructure and human capacity development needs. In addition, policymakers need assistance in how to set priorities in the face of these significantly

increased resources and how to ensure sustainability.

Effective service delivery demands that wise decisions be made at the policy, planning, and budgeting stages. To do this, accurate data on the scope of the epidemic, the populations that are affected, the costs and coverage of services, and the likely impact of different strategies are needed to inform decisionmaking. POLICY's work in the field of resources and data for decisionmaking has focused on improving understanding of epidemic dynamics; building government, civil society, and private sector capacity in HIV-related planning and finance; and ensuring appropriate finance mechanisms to support policy and program implementation. POLICY has led efforts to develop user-friendly, innova-

tive, and flexible tools to improve planning and financing for HIV policies and programs (see Box 5). With these tools and technical assistance, government officials in charge of planning and budgeting are better able to do their jobs, while civil society policy champions can play a role in the process and advocate for needed strategies and investments. The project has worked with government planners and civil society and private sector organizations to conduct strategic planning exercises that include broad participation. These efforts have also facilitated formulation of realistic action plans to achieve specific goals and increased mobilization and more efficient allocation of resources, thereby increasing the likelihood of effective implementation of policies and programs.

BOX 5

COMPUTER MODELS AND TOOLS: DYNAMIC AND RESPONSIVE

Computer models play an important role in supporting policy activities at organizational, national, and global levels. POLICY created new models and modified existing ones to meet the changing needs for policy development. A primary purpose of the user-friendly models is to build in-country planning capacity to sustain policy and planning process and to give individuals the skills and tools to devise strategies to meet local needs. These tools are designed for various stakeholders, including government, civil society, and businesses. Some of the project's key HIV-related models are discussed below.

Policy formulation. A new model, *Workplace Policy Builder*, was created with support from USAID and the Department of Labor to assist corporations in developing countries to design HIV policies. The model leads the users through the various steps of assessment, analysis, consultation, drafting, review, and approval. It stresses the importance of consultation with stakeholders (e.g., unions) and provides numerous examples of corporate policy statements to assist in the writing of sound workplace policies.

Planning. Several new models were developed under POLICY to support policy development and planning. The *PMTCT Model* shows the costs and benefits of implementing a comprehensive program to prevent MTCT and the effects of seven different options for treatment, infant feeding, and type of delivery (e.g., vaginal or Cesarean). The *AIDS Impact Model* has been updated to provide new projections of the number of orphans by age, sex, type, and cause, and the need for and effects of programs to prevent and treat HIV infection in children.

Resource allocation and mobilization. As new HIV issues emerge, policy models have been designed to assist in the allocation and further mobilization of resources to meet those needs. The *Resource Needs Model* was created in 2001, jointly with Mexico's National Institute for Public Health and Inter-American Development Bank. The model estimates the resources needed to achieve the UNGASS goals. This model continues to be used at the global level to update estimates of resources needed, and at the national level for costing out HIV strategic plans and various donor requests (e.g., GFATM applications). Effective allocation of available resources has always been a key HIV challenge. The *Goals Model* was developed in 2002 in conjunction with HORIZONS to estimate the resources needed to achieve national goals and the effects of different patterns of resource allocation. Several countries have used the model to estimate the level and allocation of resources required to achieve goals for HIV prevention, treatment, care, and support. In 2004, the *Condom Requirements Model* was created jointly with the United Nations Population Fund to estimate the number of condoms required for family planning and for HIV and STI prevention at the country level.

IMPROVING UNDERSTANDING OF EPIDEMIC DYNAMICS AND RESOURCE NEEDS

POLICY has adapted its models and tools to address various aspects of the HIV pandemic. As part of this work, POLICY contributes to the development of UNAIDS global estimates of HIV prevalence, new HIV infections, AIDS orphans, AIDS cases, and AIDS deaths, which are published in UNAIDS' global HIV pandemic updates every

two years. POLICY's AIDS Impact Model has been a key resource for helping stakeholders understand the impact of the epidemic in their own countries, while the Human Capacity Development Model estimates the training and staffing needed to carry out programs. In particular, POLICY has sought to link data on the nature of the pandemic to evidence on program impacts and effectiveness, for example,

through the Goals Model. Projections and data from this model have been essential for helping donors, governments, and other stakeholders assess the state of the pandemic, the level of services being provided, and the additional resources and types of interventions needed for achieving future goals. Box 6 discusses how POLICY's tools have aided in planning and setting goals for the President's Emergency Plan.

UNDERSTANDING OF EPIDEMIC DYNAMICS AND RESOURCE NEEDS

| Type | Year | Focus Area | POLICY Role |
|-------------------|----------------------|--|---|
| Global | 2001 | Resources required | In preparation for UNGASS, contributed to a study of resources required to expand the global HIV response, estimating that \$9.2 billion would be needed annually by 2005 and supporting the call for a global fund |
| | 2001 2003 2005 | Coverage of HIV services | Conducted surveys of essential services in 2001 and 2003; the 2003 study of 73 countries found that only 8 percent of pregnant women had access to PMTCT services and less than 1 percent of adults used VCT services; another round of the study will be conducted in 2005 |
| National | 2001 | Estimating HIV prevalence (Malawi) | Collaborated with the National AIDS Control Program to estimate adult HIV prevalence in Malawi |
| | 2002 | Resources required (Cambodia) | Assessed resources required to implement Cambodia's 2001–2005 HIV/AIDS National Strategic Plan |
| | 2004 | Resources required (India) | Conducted a resource needs assessment for scaling up the National AIDS Control Program |
| Regional/Sectoral | 2002 | Resources required (Latin America and Caribbean) | Used the Resource Needs Model to analyze resources required for combating HIV in more than 20 Latin American and Caribbean countries |
| | 2004 | Care and treatment (various) | In support of United Nations reference groups, analyzed the cost of ensuring care and treatment in Cameroon, Ghana, India, South Africa, Thailand, and Zambia |

BOX 6

ACHIEVING THE EMERGENCY PLAN GOALS: 2-7-10

POLICY's work, using the Goals Model, on resources required and the potential impact of such investments helped influence, in part, the outlining of the Emergency Plan's goals of treating 2 million people living with HIV, averting 7 million new infections, and providing care to 10 million people affected by the pandemic.

In addition, POLICY has worked with a number of countries to help incorporate the Goals Model into their response. In Ethiopia, POLICY worked directly with the U.S. Government team to provide input to the Country Operational Plan. In Kenya, POLICY worked with the National AIDS Council to prepare the national strategic plan. The model has been used to address two key questions:

- How much funding is required to provide comprehensive coverage of all prevention, treatment, and care interventions?
- What impact can be expected from achieving comprehensive coverage? (Impact has been examined in terms of infections averted from prevention and AIDS deaths averted from advanced treatment.)

Having this type of data and the ability to analyze different scenarios tailored to the in-country context is helping planners and policymakers determine how they can best use Emergency Plan funds and achieve the greatest impact.

BUILDING PLANNING AND FINANCE CAPACITY

Strengthening in-country capacity to analyze data for monitoring and evaluating HIV prevalence, trends, and impact is a cornerstone of POLICY's work. Capacity building is geared toward ensuring that counterparts thoroughly understand the procedures and can use the tools and models independently. This approach helps ensure sustainability of planning efforts and facilitates policies and plans that are locally determined. Participatory planning also strengthens commitment and buy-in by key

stakeholders as they are able to see for themselves the impact of various strategies and funding levels. POLICY has worked with partners on resource allocation exercises in various countries. In Honduras, Kenya, and Lesotho, POLICY assisted in applying the Goals Model to obtain additional funds for HIV programs from GFATM. In Nepal, POLICY worked with civil society to involve them in that country's HIV resource allocation process. By the end of the POLICY Project, 10 of the 15 Emergency Plan focus countries will have completed a Goals application.

ENSURING FINANCE/ RESOURCE MECHANISMS

Whether the task at hand is scaling up effective strategies for preventing MTCT, providing universal access to ARVs, establishing VCT clinics in rural areas, or supporting legal services to redress discrimination, mobilizing adequate resources is closely linked to the success of prevention, treatment, and care programs. A primary objective for POLICY is to help ensure that financing and resource mechanisms are in place to carry out strategic plans, national policies, and organizational programs.

CAPACITY IN PLANNING AND FINANCE

| Type | Year | Focus Area/Group | POLICY Role |
|----------------|------|---|--|
| Government | 2002 | Building political commitment (Mali) | Assisted the Ministry of Health in developing projections based on the AIDS Impact Model to present to a presidential advisory group; the President of Mali made extensive use of the projections with various audiences (e.g., religious leaders, armed forces) and commissioned a local language video for use in community settings |
| | 2004 | PMTCT (Ukraine) | Provided technical assistance to the Ministry of Health and PMTCT Working Group in planning and budgeting for the country's PMTCT program; in particular, assisted with the Budget Requirement Analysis using the PMTCT computer model |
| Private Sector | 2001 | Impala Platinum (South Africa) | Provided technical assistance to Impala Platinum to develop and adopt a workplace HIV policy; Impala employs more than 28,300 workers |
| | 2004 | Chinese Garment Manufacturers (CGM) (Lesotho) | Provided training on the Workplace Policy Builder software, as well as technical assistance on implementing workplace policies for CGM representatives; CGM employs more than 7,000 workers in Lesotho |
| Civil Society | 2001 | Strategic planning in the NGO sector (Haiti) | Strengthened the strategic planning capacity of the Child Health Institute, which drafted the National HIV/AIDS Strategic Plan for approval by the Ministry of Health |
| | 2004 | Involvement of people living with HIV (Vietnam) | Built the capacity of people living with HIV to participate in policymaking forums in Vietnam, on issues such as sustainability of ARVs provided through international donor initiatives and regulation of ARV provision in the private market |

ENSURING FINANCE/RESOURCE MECHANISMS

| Type | Year | Focus Area | POLICY Role |
|------------------|------|--|--|
| Government | 2002 | Resource allocation at the national level (Kenya) | During Kenya's mid-term review, assisted the National AIDS Control Council in assessing progress made toward reaching national goals and determined that an additional \$60 million would be needed for prevention and \$76 million for ARVs |
| | 2002 | Resource allocation at the national level (South Africa) | Used Goals to analyze South Africa's "Enhanced Response to HIV/AIDS and Tuberculosis," which identified funding and knowledge gaps and led to increased resources for programs focusing on HIV transmission through sex work, condom provision, and care interventions |
| | 2005 | Facilitating GFATM funding processes (Honduras) | Contributed to an independent review of Honduras' achievements with GFATM Phase I funding that identified errors in the local funding agent's initial assessment; the review enabled Honduras to receive \$15 million of Phase II funding |
| Societal Sectors | 2001 | Resource mobilization at the state level (Mexico) | Collaborated with MCGs to advocate for the First Social Co-investment Fund for Health in the State of Mexico, including an earmark of 1 million pesos (US \$110,000) to fund HIV projects for NGO members of the MCGs |
| | 2003 | Leveraging resources for people living with HIV (Nigeria) | Provided technical assistance to the Organization for Positive Productivity, resulting in World Bank funding to implement a project on mitigating the impact of HIV in Nigeria's Federal Capital Territory |
| | 2003 | NGO funding guidelines (South Africa) | Drafted the "National Funding Guidelines: For NGOs Receiving Funds from the Chief Directorate: HIV/AIDS, STIs and TB," which establish a transparent NGO fund-disbursement and monitoring system |
| | 2004 | Leveraging resources for the community level (Southern Africa) | Distributed grant applications and provided proposal writing assistance, leading to POLICY-supported NGOs in Lesotho and Swaziland receiving World Bank grants |

POLICY helps stakeholders set priorities and make decisions about how to allocate resources, considering issues such as cost-effectiveness and equity. POLICY's work to improve understanding of pandemic dynamics and build strategic planning and finance capacity often leads to greater mobilization of resources in the public and private sectors, as well as for civil society groups (for examples of national-level resource allocation, see "Policy | People | Practice 6"). The Workplace Policy Builder software that POLICY helped develop has now been applied in China, Kenya, Lesotho, Mexico, Mozambique, and Namibia, resulting in increased resource mobilization.

6

PUTTING THE GOALS MODEL TO WORK: LESOTHO AND VIETNAM

For national HIV responses to be effective, national strategies need to have realistic goals and must be underpinned by adequate financial resources. In 2000, the Government of Lesotho published a three-year National AIDS Strategic Budget (2001–2003). A multisectoral team used the Goals Model to determine the most cost-effective means to achieve the best combination of results in the national plan's seven goal areas. The Lesotho team used the model to prepare alternative budget scenarios and examine the feasibility of achieving the stated goals at lower cost. Analysts assisted government planners in preparing a summary and detailed inventory of funding needs and goals that could be presented to potential donors. Through the modeling process, the team discovered that achieving a drop of 19 percent in HIV prevalence would require a three-year national budget of not less than US\$100 million and not more than US \$275 million. Consequently, a new budget was designed that more realistically reflected the country's capacity, goals, and proposed activities. This lower and more realistic budget was achieved through optimization of resource allocation levels, which would have been difficult to determine without a tool such as the Goals Model.

As a result of the training received at the POLICY-facilitated regional workshop on HIV advocacy and resource allocation, staff from the AIDS Division of Vietnam's Ministry of Health applied the Goals Model to inform the National HIV/AIDS Strategy and the accompanying budget for 2004. This resulted in a recommendation to the National Assembly that the budget be increased from 60 billion Vietnamese Dong (US \$3,950,000) to 80 billion Vietnamese Dong (US \$5,300,000), representing a 33 percent increase in the government's HIV budget.

REDUCING VULNERABILITY



PHOTO CREDIT: PALANI MOHAN

Addressing gender inequality, reducing stigma and discrimination, and meeting the needs of youth are essential for preventing the spread of HIV and improving treatment and care.



REDUCING VULNERABILITY

Through the Siyam'kela Project, HIV-positive people and faith-based leaders are working together to combat stigma and discrimination in South Africa.





PHOTO CREDIT: CHRISTINA STUCKY

POLICY BRIEF: REDUCING VULNERABILITY

- Expanded prevention, treatment, and care programs are doomed for failure if they do not reduce vulnerability to HIV infection and meet the needs of society's most vulnerable groups.
- Gender inequality, stigma, poverty, and marginalization increase vulnerability to HIV infection and hinder the ability of individuals and families to cope with the disease.
- The impact of HIV is felt across society and not only by those directly affected by HIV—efforts to reduce HIV vulnerability, therefore, will improve programs and outcomes not only for people living with HIV and vulnerable groups but also for the broader society.
- Policies and participatory planning process can help break the silence and stigma surrounding HIV, change norms that increase vulnerability (e.g., lower status of women), and protect the rights of vulnerable and affected groups.



PHOTO CREDIT: RICARDO RAMÍREZ ARRIOLA

Through the Mo Kexteya Project, Anuar Luna—co-founder of the Mexican Network of People Living with HIV/AIDS—helps build the capacity of HIV-positive people to overcome internal stigma.

The notion of “vulnerability” recognizes that factors such as *society* (e.g., access to services, socioeconomic factors), *self* (e.g., individual capacity and skills), and *situation* (e.g., power relationships in a given situation) have an impact on the spread of and response to HIV. Given this, the pandemic often takes hold by affecting groups that are already socially and economically disadvantaged. Groups disproportionately affected by the pandemic include women and orphans as well as more marginalized communities, such as prostitutes, IDUs, and MSM. Despite the best of intentions, expanded prevention, treatment, and care initiatives are doomed for failure if they do

not adequately address the factors that increase vulnerability to HIV infection and if they do not consider the needs of the most vulnerable groups. Issues such as gender inequality, poverty, stigma, and marginalization exacerbate vulnerability to HIV infection and hinder the ability of individuals and families to cope with the disease.

Essential strategies for addressing vulnerability include reducing stigma, discrimination, and gender inequality; meeting the needs of people living with HIV, women, youth, orphans and vulnerable children, and other vulnerable groups; and promoting human rights. Policies and participatory planning processes can help break

the silence and stigma surrounding HIV, change norms that increase vulnerability (e.g., lower status of women), and protect the rights of vulnerable groups. Given that the impact of HIV is felt across society and not only by those directly affected, efforts to reduce HIV vulnerability will improve programs and outcomes not only for people living with HIV and vulnerable groups but also for the broader society.

POLICY's crosscutting issues are to promote human rights and reduce stigma and discrimination, encourage gender-sensitive responses, and address the needs of youth and orphans and vulnerable children. These are issues that USAID and POLICY have found to be critical for reducing vulnerability to HIV and for increasing meaningful participation in the policy process.

ELIMINATING STIGMA AND DISCRIMINATION, PROMOTING HUMAN RIGHTS

Perhaps more than any other disease, HIV raises issues surrounding stigma, discrimination, and human rights. People living with HIV and those from vulnerable groups face various forms of stigma and discrimination—from rejection by family and friends to physical abuse and gender-based violence to internalized stigma to lack of high-quality healthcare to the loss of employment, housing, and educational opportunities. Without human rights protections, people living with HIV and vulnerable populations are too often subject to stigma, discrimination, and rights violations—causing them to avoid seeking out and adhering to needed treatment and care services. Even when discrimination does not take place, the fear of negative responses can cause people to avoid learning and disclosing their HIV status,

which is the first step in preventing future infections. Furthermore, challenging deep-seated beliefs regarding HIV, promoting an environment free from stigmatizing attitudes, and rolling out programs to meet the needs of vulnerable groups requires a multisectoral effort. People living with HIV and vulnerable groups must be involved in this effort; those most at-risk are in the best position to address specific issues. However, meaningful participation is often not possible in a stigmatizing environment.

As POLICY's HIV work expanded, the project made addressing stigma, discrimination, and human rights a priority. By 2002–2003, the project's heightened level of commitment provided direction for the more than 120 stigma, discrimination, human rights, and GIPA-related field activities. As a result of this attention, POLICY helped bring new partners into the policy arena, strengthened the

capacity of people living with HIV and vulnerable populations, and enhanced the responsiveness of policies and guidelines that govern program

implementation. Specific activities include mobilizing groups to combat stigma; developing tools and guidelines for stigma and discrimination reduction;

conducting legal reviews and reform; and monitoring rights violations of vulnerable groups (for an example, see “Policy | People | Practice 7”).

STIGMA, DISCRIMINATION, AND HUMAN RIGHTS

| Type | Year | Focus Area | POLICY Role |
|---|-----------|---|---|
| Mobilization to Combat Stigma and Discrimination | 2003 | Faith-based organizations (Zambia) | Supported the Zambia Interfaith Networking Group on HIV/AIDS to organize a conference for religious leaders on the rights of people living with HIV and to secure commitment to combat stigma and discrimination |
| | 2005 | Business coalition (Mexico) | Facilitated formation of the National Business Council on HIV/AIDS, comprised of more than 20 multinational corporations and dedicated to reducing HIV-related discrimination in the workplace |
| Guidelines and Tools to Reduce Stigma and Discrimination | 2001 | Workplace guidelines (Zambia) | Provided technical assistance to the Women and Law in Southern Africa NGO to prepare “Guidelines on HIV/AIDS and Employment,” which were adopted by the National HIV/AIDS Secretariat and the Zambia Business Coalition on HIV/AIDS |
| | 2001–2004 | Indicator development and stigma reduction guidelines (Mexico and South Africa) | Conducted formative research leading to the development of indicators to measure stigma and discrimination and guidelines for reducing stigma in various sectors |
| | 2003 | Human rights training curricula (Cambodia) | Assisted the Cambodian Human Rights and HIV/AIDS Network in the design of human rights training curricula for the health sector, workplace, and the family and community |
| Policy Formulation and Legal Review | 2001–2004 | Legislative review (Tanzania) | Assisted the Tanzania Women Lawyers Association to review laws affecting HIV in Tanzania and prepare recommendations that were presented to the Ministry of Justice and Constitutional Affairs |
| | 2003–2004 | Human rights audit (Cambodia and Nepal) | Assessed the degree to which legal systems in Cambodia and Nepal are consistent with the International Guidelines on HIV/AIDS and Human Rights |
| | 2004 | Legal reform (Peru) | Provided technical assistance to Colectivo por la Vida in its successful advocacy efforts to change Peru’s AIDS law to better address the needs and rights of people living with HIV, including anti-discrimination language and provision of free services and medications |
| Monitoring Rights Violations/Meeting the Needs of Vulnerable Populations | 2003–2005 | Reproductive health for HIV-positive women (Ukraine) | Assessed barriers that HIV-positive pregnant women face when seeking reproductive health services; as a result, helped influence adoption of a new PMTCT program for 2005–2008 and a national VCT protocol |
| | 2004–2005 | Health sector (Cambodia) | Supported Vithey Chivit to monitor human rights violations of people living with HIV seeking services in public hospitals, make referrals to human rights centers, and conduct HIV sensitization training for health workers |

7

MULTISECTORAL RESPONSES TO STIGMA AND DISCRIMINATION

Recognizing the need to address stigma and discrimination in various contexts, in 2001, POLICY embarked on stigma-reduction initiatives in South Africa and Mexico. These countries were chosen because they represent two different epidemics—one a high prevalence, generalized epidemic that has hit women and the poor particularly hard; the other a low prevalence, concentrated epidemic that has primarily affected vulnerable groups such as MSM. Together, the two initiatives focused on people living with HIV, the media, faith-based organizations, workplaces, healthcare settings, and public policy.

The formative research phase resulted in a conceptual framework for stigma and discrimination and indicators to assess different aspects of the issue (POLICY Project et al., 2003; National Institute of Public Health et al., 2004). In particular, POLICY highlighted the need to measure and address internal stigma felt by people living with HIV and vulnerable groups. POLICY has shown how internal stigma at the individual level causes people to adopt protective actions such as withdrawal or isolation to avoid stigma and discrimination, thereby hindering prevention, treatment, and care.

“We have to focus on the person, because the first impact of the epidemic is at a personal level,” states Anuar Luna of the Mexican Network of People Living with HIV/AIDS.

Through USAID’s Stigma and Discrimination Indicators Working Group, POLICY is collaborating with others in an effort to design valid indicators to help program managers better understand the dimensions of stigma and discrimination and develop appropriate responses. In the implementation phase of POLICY’s stigma initiatives, in-country partners are being trained to carry out their own stigma-mitigation projects.

For people like Joe Nkosi, chairperson of St. Joseph’s HIV/AIDS Support Group in Eersterus township in South Africa, the training has had a noticeable impact. He notes, “We approach our community with more confidence and more insight into HIV and AIDS. Any project we tackle is with vigor and it’s well planned. There’s total commitment.”



PHOTO CREDIT: BARAKA KARARA

The Orongo Widows and Orphans Group, founded by Florence Gundo (left), promotes women's inheritance rights and HIV awareness in western Kenya.

MAINSTREAMING GENDER

In 2005, there were 17.5 million women living with HIV. The proportion of HIV-positive women has increased steadily in almost every region during the past five years, and women now represent nearly half of all people living with HIV worldwide. Gender norms and inequalities affect all aspects of the HIV pandemic, from vulnerability to infection to the ability to seek and access treatment and care services. For example, many women—regardless of serostatus—fear violence, rejection, blame, abandonment, and loss of economic support following HIV testing and disclosure (Maman et al., 2001; Temmerman et al., 1995; USAID and Synergy Project, 2004),

thereby limiting prevention efforts. Lack of control over household resources and decisionmaking hinders the ability of women to seek and adhere to treatment and care. Furthermore, gender norms surrounding masculinity⁵ exacerbate HIV risk for both men and women.

Gender issues must be addressed hand-in-hand with other HIV issues and, therefore, POLICY integrates gender considerations into each aspect of its work. The project has provided technical leadership in addressing increasingly complex gender issues. Some of these issues include helping countries mainstream gender across HIV policies and programs; increasing male involve-

ment in HIV responses; strengthening HIV-positive women's leadership; and analyzing the link between HIV and gender-based violence. In particular, POLICY has sought strategies to address the way in which crosscutting issues often intersect, for example how stigma and discrimination interact with gender inequality (for an example, see "Policy | People | Practice 8"). Furthermore, POLICY staff played a leading role in providing gender sensitization and integration training through USAID's Interagency Gender Working Group and prepared a gender integration guide as part of the working group's Gender and HIV/AIDS Task Force.

5. "Gender norms for masculinity often dictate that men and boys should be knowledgeable, experienced, and capable of taking the lead in sexual relationships. Multiple partners for men are condoned in many societies, as is sexual risk-taking and the early initiation of sexual activity. Boys and men sometimes remain uninformed about HIV/STI prevention because admitting their lack of knowledge in this area could be construed as a weakness" (Gender and HIV/AIDS Task Force/Interagency Gender Working Group, 2004, p. 3).

GENDER

| Type | Year | Focus Area | POLICY Role |
|---|-----------|--|--|
| Gender-integrated Public Policy and Programs | 2002 | Gender mainstreaming at the national policy level (Kenya) | Co-convened the Gender and HIV/AIDS Technical Subcommittee that designed the gender mainstreaming strategy adopted by the National AIDS Control Council; also created gender integration tools and conducted advocacy training to enable stakeholders to put policy recommendations into practice |
| | Ongoing | Government-civil society partnership/community mobilization and capacity building (South Africa) | As part of the “Women in Partnership Against AIDS” and “Men in HIV/AIDS Partnership” initiatives, led participatory planning processes that assessed women’s and men’s needs in relation to HIV, and encouraged their meaningful involvement in implementation of the national strategic plan |
| Gender Equality | 2003–2004 | Status of women within communities (Cambodia) | Supported Wat Norea Peaceful Children to establish a Wisdom Group made up of 40 monks and community leaders; these leaders subsequently revised the Women’s Code to provide alternatives to code elements that contributed to gender-based violence and women’s subordination |
| | 2004–2005 | Inheritance rights (Kenya) | Worked with women’s groups to devise a new advocacy approach focusing on identifying community cultural structures impeding women’s property rights; traditional leaders declared their support for assuring women’s inheritance of property, and committed to communicating this position to men in the community |
| HIV-positive Women’s Leadership | 2004 | Support group formation (Nepal) | Facilitated the formation of Sneha Samaj, the first-ever support group of and for women and children living with and affected by HIV in Nepal |
| Research and Emerging Gender Issues | 2001–2005 | Evidence-based gender programming and emerging issues (Global) | As part of the Gender and HIV/AIDS Task Force, conducted expert interviews and contributed to the preparation of a gender and HIV integration guide |
| | 2005 | Gender and MSM (Cambodia and Vietnam) | Conducted situation assessments regarding gender norms and sexual identities relating to MSM to inform development of HIV prevention and care policies and programs for MSM |
| | 2005 | Gender-based violence (Mekong Region) | Conducted a literature review and interviews of key informants to guide the development of an advocacy paper that analyzes the links among gender-based violence, women, and HIV |

8

THE INTERSECTION OF HIV, GENDER, STIGMA, AND HUMAN RIGHTS: FIGHTING FOR WOMEN'S PROPERTY AND INHERITANCE RIGHTS IN KENYA

In Kenya, many women who have lost their spouses to HIV/AIDS have been denied inheritance rights. Despite appropriate legal and policy reforms, community and social relations and traditional decisionmaking structures still pose major constraints to equitable inheritance. The situation prompted POLICY to support an advocacy project on inheritance and women's rights in Kenya.

"When a husband dies of HIV/AIDS (whether a woman is HIV-negative or not), the in-laws will often circulate the death certificate so that the widow will be subject to stigma and discrimination in order to isolate her. She may not even feel worthy of the inheritance because of this sense of isolation," says Angeline Siparo, POLICY/Kenya Country Director (quoted in Feldman-Jacobs, 2004, para. 18).

POLICY's inheritance rights project has been implemented in four phases: 1) situational assessment; 2) community-based field work; 3) development of an advocacy strategy; and 4) implementation of advocacy campaigns. Collaborating partners in the project have included groups such as the Kenya Human

Rights Commission, Jaramogi Oginga Odinga Foundation, and the Orongo Widows and Orphans Group. Among the groups targeted by the advocacy efforts are family court judges and magistrates, chiefs, village elders, district commissioners, and women themselves.

"We started teaching women in churches, schools, and even during funerals, and gradually their attitude started changing. If a woman knows her rights, she will not follow a custom that will not do her any good," says Florence Gundo, who helped establish the Orongo Widows and Orphans Group in Kisumu District in 1997 and has been actively involved in the inheritance rights project.

With support from POLICY, local groups have been able to reclaim land for widows and have inspired community and traditional leaders to publicly state their support for women's inheritance and property rights. These are important first steps in breaking the cycle of gender inequality, poverty, and increasing vulnerability to HIV brought about by the epidemic.

ADDRESSING THE NEEDS OF YOUTH AND ORPHANS AND VULNERABLE CHILDREN

Half of the 13,000 new infections that occur each day are in the 15 to 24 age group, with young females disproportionately affected. Youth have special needs when it comes to HIV policies and programs, including access to youth-friendly health services, protection from harmful practices, and programs that enhance life choices and opportunities (e.g., education, employment). In addition, the pandemic has given rise to the phenomenon of AIDS orphans and vulnerable children, who have a range and care and support needs. By

the end of 2003, UNAIDS, UNICEF, and USAID (2004) estimated that there were 15 million AIDS orphans.⁶

POLICY works with governments and civil society partners to ensure that the needs of youth and orphans and vulnerable children are reflected in policy and program responses to the pandemic. The project's efforts in addressing adolescent reproductive health have often provided an entry point for tackling HIV prevention policy issues. POLICY also conducted a study of policy gaps relating to orphans and vulnerable children in sub-Saharan Africa and developed a framework of action to guide national policy

responses (Smart, 2003). POLICY's technical assistance has led to the adoption of national policies, strategic plans, and guidelines focusing on youth and/or orphans and vulnerable children in a number of countries. The project also conducts and disseminates research on the demographic impacts of HIV and facilitates advocacy for youth and orphan issues. In addition, POLICY and Youth.Net launched the www.youth-policy.com website, an online resource on youth reproductive health policies, including those relating to HIV. Since its launch in 2004, the site has hosted more than 17,000 users.

6. POLICY contributes to these estimates through the UN Reference Group on Estimates, Modeling, and Projections.

YOUTH AND ORPHANS AND VULNERABLE CHILDREN

| Type | Year | Focus Area/Group | POLICY Role |
|---------------------------------|-----------|---|---|
| Youth | 2001–2004 | Youth involvement (Jamaica) | Mentored young people by providing them with technical support and leadership skills to take an active role in planning and implementing the revised National Youth Policy and National Strategic Plan for Youth Development, which cover reproductive health and HIV |
| | 2004 | Capacity building for vulnerable youth (Nepal) | Awarded small grants to five rehabilitation centers to fund leadership training for recovering injection drug users to enable them to contribute to HIV prevention |
| | 2004–2005 | Policy advocacy (Peru) | Strengthened the capacity of a coalition of 24 youth-focused NGOs that successfully advocated for Ministry of Health guidelines to promote universal adolescent access to health services, with special emphasis on mental and reproductive health issues, including HIV |
| Orphans and Vulnerable Children | 2001 | Salvation Army Community Care Program (Swaziland) | Awarded a small grant to the Salvation Army Community Care Program to build the capacity of three communities to provide care and support for orphans and vulnerable children |
| | 2002 | Strategic planning (Nigeria) | Provided technical assistance to the Ministry of Women's Affairs and Youth Development in devising the Plan of Action on Orphans and Vulnerable Children |
| | 2002–2004 | Inter-Religious Council of Uganda | Facilitated preparation of a five-year HIV strategic plan for the Inter-Religious Council of Uganda, and provided financial and technical support to create a small grants program for 30 faith-based organizations providing services to orphans and vulnerable children |
| | 2003–2006 | Impact assessment (Cambodia) | Conducted a study of the socioeconomic impact of HIV on orphans and vulnerable children in Cambodia, in particular, looking at changes in quality of life over time |



PHOTO CREDIT: PALANI MOHAN

Wat Norea, based in Cambodia's Battambang Province, provides care and support to orphans and vulnerable children.

MULTISECTORAL ENGAGEMENT



PHOTO CREDIT: PHOTO COURTESY OF
FUTURES GROUP

POLICY works to bring new partners into the HIV policy arena. Mobilization across sectors, including among groups such as the uniformed and armed services, is essential for comprehensive HIV responses.



MULTISECTORAL ENGAGEMENT



Community-based
HIV prevention
awareness raising
in China.



PHOTO CREDIT: PALANI MOHAN

POLICY BRIEF: MULTISECTORAL ENGAGEMENT

- The pandemic is a development challenge that has an impact on all sectors and groups in society, and broad social factors (such as gender inequality and poverty) influence vulnerability to HIV.
- A multisectoral policy response is required—this approach improves coordination, strengthens implementation and accountability, and increases the resources and skills brought to the response.
- Countries have greater success in combating HIV when they enact programs that build on the synergy of multisectoral efforts; if key sectors or groups are neglected or isolated, HIV will continue to make inroads.
- Multisectoral engagement can occur in various ways—**POLICY** works to improve coordination across government ministries and levels; bring new partners into the HIV policy arena; and build partnerships among government, civil society, and private sector groups.



Consejo Nacional Empresarial sobre SIDA (CONAES) is a coalition of multinational corporations operating in Mexico that seeks to reduce workplace discrimination.

PHOTO CREDIT: MARIA BORDA



PHOTO CREDIT: COURTESY OF POLICY/MEXICO

Members of the State of Mexico's Multisectoral Citizens Group march on World AIDS Day 2004.

HIV is more than a health issue alone; it is a development challenge that has an impact on all sectors and groups in society. The education sector, for example, must consider issues such as how AIDS-related deaths among teachers will affect the education of future generations, how best to raise awareness about HIV prevention, and how to meet the educational needs of orphans and vulnerable children. The labor sector and businesses must consider how HIV affects the workforce and how the resources of these sectors can be harnessed to provide improved prevention, treatment, and care services. In addition, broad social forces, such as gender inequality and poverty, affect vulnerability to HIV and limit the ability of families to cope with infection.

For example, poor women—lacking access to or control over resources—may turn to transactional sex to meet their families' basic needs, thereby increasing their vulnerability to HIV. These types of socioeconomic conditions can only be addressed through comprehensive, society-wide efforts. The HIV pandemic, therefore, requires a multisectoral policy response.

All sectors of society—government, civil, and private—must play a role in responding to and mitigating the impact of the pandemic. Multisectoral engagement can strengthen implementation and accountability and increase the resources and skills that are brought to the response. Country responses have experienced greater success in com-

bating HIV when they enact comprehensive programs and build on the synergy of multisectoral efforts, demonstrating that the sum is greater than the individual parts of the whole. If key sectors or groups are neglected or isolated, HIV will continue to make inroads.

Collaboration can improve HIV responses and can also help facilitate broader societal development. For example, citizen participation in HIV policymaking helps promote democracy and good governance, while the general knowledge and skills individuals and organizations gain through human capacity development activities for HIV (e.g., planning, advocacy, budgeting, and networking) can be used in various other policy arenas.



PHOTO CREDIT: COURTESY OF POLICY/NEPAL

Launch of the Nepal Police HIV/AIDS training curricula, strategy, and workplan in April 2005.

The examples below illustrate how POLICY has provided technical leadership in the development of multisectoral responses and innovative partnerships for combating HIV. POLICY has encouraged multisectoral engagement in three main ways: improving coordination among government ministries and across levels (e.g., national, district); bringing new partners into the HIV arena (e.g., businesses, faith-based organizations, NGOs); and building government-civil society partnerships.

STRENGTHENING COORDINATION ACROSS GOVERNMENT MINISTRIES, AGENCIES, AND LEVELS

The national government is a key actor in creating an enabling environment for HIV programs based on its authority to develop and adopt policies,

plans, laws, and budgets. However, the nature of the pandemic requires that it not be addressed by the national health department alone, but across ministries, agencies, and levels of government. Each ministry or level, working in a coordinated manner, can address a different aspect of the pandemic and bring additional resources and capacity to the country's response. While POLICY, early on, was concerned primarily with national policy development, the project quickly moved to mobilize ministries and departments that had not previously addressed HIV. The project also recognized the importance of expanding responses to the local level and, therefore, worked to ensure that subnational government units are better able to respond to HIV at provincial, district, and local levels.



PHOTO CREDIT: MARIA BORDA

Dr. Patricia Uribe—former head of the **National Center for the Prevention and Control of HIV/AIDS**—played a leading role in supporting the **Mutlisectoral Citizens Group** approach in Mexico.

GOVERNMENT

| Type | Year | Department/Unit/Group | POLICY Role |
|---|------|---|--|
| Ministries | 2002 | Ministry of Women's and Veterans' Affairs (Cambodia) | Assisted the Ministry of Women's and Veterans' Affairs to develop a three-year HIV strategic workplan focusing on women and girls |
| | 2003 | Ministry of Defense (Nigeria) | Provided technical assistance and review leading to the adoption of the Armed Forces Policy on HIV/AIDS |
| | 2005 | Nepal Police | Helped the Nepal Police to design an HIV strategy and training curricula |
| Subnational Government Responses | 2001 | Social Services, Transport, and Education departments of Gauteng Province (South Africa) | Assisted three provincial government departments to develop HIV plans that provide care and support services, such as support grants to caregivers of orphans and vulnerable children |
| | 2002 | Local Government Units (Philippines) | Facilitated formation of local AIDS councils, leading to passage of city HIV ordinances and mobilization of additional resources for HIV programs |
| | 2003 | District HIV/AIDS Task Forces (Zambia) | Strengthened the capacity of 11 district HIV/AIDS task forces and facilitated formation of the Southern Province HIV/AIDS Advocacy Alliance, which includes members from each task force |
| Regional Collaboration | 2001 | Commonwealth Regional Health Community Secretariat (Eastern and Southern Africa) | Provided technical assistance resulting in ministers of health from 14 countries adopting the "Regional HIV/AIDS Strategy for East, Central, and Southern Africa, 2002–2006," which set forth a plan for a regional response for prevention, treatment, and care |
| | 2005 | Orphans and Other Vulnerable Children Rapid Country Assessment, Analysis, and Action Planning (RAAAP) Initiative (sub-Saharan Africa) | Conducted rapid assessments of national efforts to provide care and support on behalf of the Orphans and Other Vulnerable Children RAAAP Initiative, which aims to unify and scale up multisectoral national responses to the orphan crisis in 17 countries |



PHOTO CREDIT: COURTESY OF TUMAINI WOMEN'S GROUP

The Tumaini Women's Group in Tanzania received a small grant to support income-generating activities and training for women and children affected by HIV.

BRINGING NEW PARTNERS INTO THE HIV POLICYMAKING ARENA

While the policy arena has traditionally been the domain of government officials and politicians, POLICY recognizes the importance of involving civil society and private sector partners in combating the pandemic. These groups are often better positioned to reach vulnerable groups and are integral to breaking the stigma and silence surrounding HIV. They can draw attention to the needs of specific populations, such as women, youth, and children, who may lack a voice in the policymaking process. Civil society and private sector

groups—such as faith-based organizations and businesses—can also play a role in preventing HIV among their constituencies and supporting treatment and care programs. Mobilizing civil society and private sector involvement has been critical to POLICY's approach in fostering broad-based support for HIV policies and programs (see “Policy | People | Practice 9” and “Policy | People | Practice 10”). To facilitate these efforts, the project developed tools, models, and guides for mobilizing different sectors and groups, including NGOs, faith-based organizations, and vulnerable groups.⁷

7. For examples, see “Learning Through Practice: Integrating HIV/AIDS into NGO Programmes—A Guide” (POLICY Project and Chief Directorate: HIV/AIDS, STIs, and TB/South African National Department of Health, 2003); “Planning Our Response to HIV/AIDS: A Step by Step for HIV/AIDS Planning for the Anglican Communion” (Judge and Schaay, 2001); “Networking for Policy Change: An Advocacy Training Manual” (POLICY Project, 1999); “Guía de incidencia política en VIH/SIDA: Hombres gay y otros hsh” (Mayorga, Montoya, and Perez, 2003); and “HIV/AIDS and the Public Sector Workforce: An Action Guide for Managers” (Rau, 2004).

CIVIL SOCIETY AND PRIVATE SECTOR

| Type | Year | Group/Sector | POLICY Role |
|--|-----------|---|--|
| Workforce | 2002 | Confederation of Ethiopian Trade Unions | Provided technical assistance leading to the development and passage of an HIV workplace policy by the Confederation of Ethiopian Trade Unions, which encompasses 400 trade unions with approximately 400,000 members |
| | 2001–2003 | University of Stellenbosch (South Africa) | Developed training materials for the “Post-Graduate Diploma in HIV/AIDS Management in the World of Work” for the University of Stellenbosch and provided technical assistance to students designing workplace policies |
| | 2004–2005 | Labor unions (Haiti) | Supported policy dialogue and technical assistance to three central labor unions to develop strategic HIV action plans |
| Faith-based Organizations | 2002 | Christian response to HIV (Haiti) | Organized a workshop on HIV responses for Anglican, Catholic, and Protestant churches, resulting in religious leaders signing a commitment to address HIV |
| | 2002–2005 | Islamic Network for the Fight Against HIV/AIDS (Mali) | Provided technical and financial assistance to Islamic leaders to create a registered network, formulate a policy on HIV and care for people living with HIV, and prepare a three-year strategic plan |
| NGOs and Community-based Groups | 2001 | Women’s Network for Peace (Guatemala) | Worked closely with the Women’s Network for Peace on a strategy for civic surveillance and monitoring of policies pertaining to family planning, safe motherhood, and HIV |
| | 2004 | HIV service NGOs (Ukraine) | Supported formation of the Coalition of HIV Service NGOs that coordinates activities to broaden NGO participation in prevention and care, share best practices and emerging technologies, and promote transparency in the government’s response |
| People Living with HIV and Vulnerable Populations | 2003 | MSM (Latin America) | Strengthened the advocacy skills of MSM from 13 Latin American countries and prepared an advocacy guide to build capacity to strengthen HIV prevention and care strategies |
| | 2004 | Kenya Association of Positive Teachers (KENEPOTE) | Provided technical and financial assistance to KENEPOTE to form a network of HIV-positive teachers and host its first national forum |
| Media | 2004 | Association of Journalists Against AIDS in Tanzania | Supported the advocacy efforts of the Association of Journalists Against AIDS in Tanzania, including development of a listserv and electronic discussion forums, media engagement in policy dialogue, and activities to encourage improved HIV reporting |
| | 2004 | Alliance of Media Advocates (Honduras) | Facilitated formation of the Alliance of Media Advocates, which includes people living with HIV and media professionals who have come together to monitor media coverage of HIV issues and promote positive portrayals of those affected by the epidemic |



POLICY SMALL GRANTS SUPPORT GRASSROOTS RESPONSES

One way in which POLICY has encouraged new partners to enter the HIV arena is through the use of small grants. POLICY II has awarded small grants to nearly 150 faith-based organizations, NGOs, women's and youth groups, networks of people living with HIV, and others to support HIV-related activities. With small amounts of funding (typically \$5,000 or less), grantees have been able to:

- Strengthen self-esteem, support treatment and literacy training, and assist in job placement for 20 HIV-positive women (*Cambodian Women's Crisis Center*)
- Advocate for FP/RH and HIV integration at the district level (*Ghana National Association of Teachers* and *Ghana Registered Midwives Association*)
- Improve strategic planning and the capacity of organizations providing HIV services for the deaf and disabled communities (*Kenya National Association of the Deaf* and *Lesotho National Federation of Organizations of the Disabled*)
- Conduct leadership training for recovering injection drug users to empower them to participate in programs to prevent the spread of HIV and meet the needs of vulnerable populations (*Kirat Yakthung Chumlung Punarjivan Kendra*, *Nepal Youth Rehabilitation Centre*, *Recovering Nepal*, *Richmond Fellowship Nepal*, *Sahara Drug Treatment & Rehabilitation Center*, and *Serene Foundation Drug Treatment and Rehabilitation Center*)
- Systematize policy information and disseminate biweekly advocacy materials among women's groups so that they can advocate for reproductive health and HIV programs and remain updated on the changing health policy context in Peru (*Centro de Documentacion Sobre La Mujer*)
- Raise awareness using drama, song, and dance as a means to encourage South African youth to abstain from premarital sex (*George Christian Support Group for HIV/AIDS*)
- Build capacity and facilitate the sharing of lessons learned among networks of people living with HIV (*All Ukrainian Charity Organization/All Ukrainian Network of People Living with HIV/AIDS*)

POLICY has also integrated its in-country grants mechanism as a component in other programs, such as the U.S. Ambassadors Initiative of USAID's Regional HIV/AIDS Program (RHAP) for Southern Africa and the pilot phase that led to the Empowerment Grants Program of USAID's CORE Initiative (Communities Responding to the HIV/AIDS Epidemic). The grants mechanism has also been adapted for special projects. For example, POLICY collaborated with the Inter-Religious Council of Uganda to build the council's capacity to plan, implement, and monitor a grants program to strengthen the role of faith-based organizations in carrying out activities that focus on supporting orphans and vulnerable children.

10

CATHOLIC BISHOPS CONFERENCE OF INDIA LAUNCHES HIV POLICY

The Catholic Bishops Conference of India (CBCI) has one of the largest networks of healthcare facilities in the country. It operates nearly 4,800 health facilities across India, which is second only to the government system. In addition to other services, CBCI facilities provide HIV prevention, care, and treatment.

CBCI's leadership recognized that its existing health policy was outdated and needed to be revised. HIV also raised moral and ethical issues that the church had to address. Therefore, the Executive Committee of the CBCI Healthcare Commission requested technical assistance from POLICY to revise its health and HIV policies in March 2004.

Dr. Sherry Joseph, POLICY/India program manager, says that developing the policy involved a year-long process that included "dialogue, broadened participation of stakeholders, and policy relevant research."

On Aug. 31, 2005, the CBCI launched the health and HIV policies in New Delhi. The HIV policy calls for a concerted and intensive response, offering a comprehensive approach toward prevention, care, and support of people living with HIV and those affected by the epidemic. Importantly, the policy states, "We do not approve of any sort of discrimination or hostility directed against people living with HIV/AIDS. This is unjust and immoral."

FACILITATING GOVERNMENT/CIVIL SOCIETY/PRIVATE SECTOR PARTNERSHIPS

POLICY has worked to build the capacity of national and subnational governments to devise sound policies. The project also collaborated with civil society and private sector groups, building their HIV-related leadership, advocacy, networking, planning, and policymaking capacity. In several countries, this experience helped POLICY serve as a bridge between different sectors, enabling government, civil society, and the private sector to come together to improve policies and programs. These partnerships have helped countries make significant breakthroughs in their response to HIV. Working together, multi-sectoral stakeholders can ensure that the needs of various groups are reflected in

policies and that broad support for implementation of HIV programs exists. For example, POLICY facilitated involvement of people living with HIV in the development of Malawi's National HIV/AIDS Policy, thereby strengthening policy provisions devoted to meeting the needs of those most affect-

ed by the pandemic (see "Policy | People | Practice 2" on page 22). In Cambodia, POLICY collaborated with the government and Buddhist organizations to raise awareness and devise mechanisms for faith-based groups to help implement the country's national HIV program.

GOVERNMENT/CIVIL SOCIETY/PRIVATE SECTOR PARTNERSHIPS

| Type | Year | Sector/Focus Area | POLICY Role |
|--|-----------|---|--|
| National Policymaking Bodies | 2003 | Orphans and vulnerable children (Kenya) | Participated in and coordinated involvement of nearly 80 multisectoral partners in preparing the National Program Guidelines for Orphans and Other Children Made Vulnerable by HIV/AIDS |
| | 2004–2005 | Country coordinating mechanisms (CCMs) of GFATM | Collaborated in devising guidelines for improving community participation in CCMs through a joint project that involved more than 400 people living with HIV |
| Resource Allocation and Data for Decisionmaking | 2003 | Data analysis and presentation (Mozambique) | Provided support to the Multisectoral Technical Group responsible for assisting the government with the interpretation of surveillance data and estimates of HIV prevalence and impact projections, as well as funding the group to conduct studies on determinants of HIV prevalence |
| | 2004–2005 | Data analysis and advocacy (Asia) | Launched the Integrated Analysis and Advocacy (A ²) project to mobilize effective HIV responses via improved analysis of epidemic dynamics and strengthened advocacy skills of government and community leaders |
| Community Mobilization | 1997–2005 | Multisectoral Citizens Groups (MCGs) (Mexico) | Provided support to various MCGs, comprising state and local organizations, that work closely with the National Center for the Prevention and Control of HIV/AIDS |
| | 2002 | Faith-based groups (Kenya) | Supported organizational capacity building and facilitated policy dialogue between the Inter-Religious AIDS Consortium and the National AIDS Control Council, leading to the government pledging to involve the consortium in HIV issues and program dialogue |
| | 2004 | People living with HIV (Vietnam) | Collaborated with the Ho Chi Minh City Provincial AIDS Council, the People's Committee of Ho Chi Minh City, and eight HIV-positive community groups to form the Ho Chi Minh City People Living with HIV/AIDS Network, the first-ever network of HIV-positive community groups in the country |

STRENGTHENING THE SYNERGY: HIV AND FAMILY PLANNING/ REPRODUCTIVE HEALTH INTEGRATION

POLICY has sought to help countries sustain political commitment for meeting FP/RH needs while also devoting adequate attention and resources to the HIV pandemic. Both FP/RH and HIV programs benefit when countries address these issues in an integrated manner. For example, limiting unintended pregnancies among HIV-positive women helps countries reach national development goals and reduce the risk of pregnancy-related complications, while at the same time reducing the potential for MTCT and the number of future AIDS orphans. Likewise, providing HIV-related counseling through antenatal clinics or reproductive health programs expands the number of women who can be reached by HIV-focused programs alone (especially in highly stigmatized areas), while encouraging family planning methods and improved reproductive health (e.g., treatment for STIs) can also aid in preventing HIV transmission. Efforts to encourage men's shared responsibility for sexual and reproductive health—typically seen as an issue for women alone—can help limit unintended pregnancies and the spread of HIV/STIs.

Repositioning FP/RH. POLICY studies of family planning use and provision in countries highly-affected by HIV demonstrate that the unmet need for family planning is still great (see Aloo-Obunga, 2003; Banda et al., 2004; Gichuhi et al., 2004; Mekonnen et al., 2004; Syacumpi et al., 2003; and Walston, 2005). Policymakers, program staff, and clients, including HIV-positive women, agree that people need access to family planning information and programs to meet their reproductive health needs. However, countries lack the resources necessary for the proper training in family planning, staff retention and stable commodity supply, and effective logistical management that an integrated program requires.

POLICY's analyses have demonstrated a need to better integrate FP/RH and HIV at the policy level. An analysis of the family planning content of VCT and PMTCT policies in 16 countries identified issues and policy gaps that hinder implementation of

an integrated health system (Strachan et al., 2004). Some of the key gaps identified include the need for a sharper focus on fertility choices for HIV-positive women, stronger linkages between VCT/PMTCT and maternal and child health/family planning departments, and an emphasis on dual protection and dual method use. In 2003, POLICY and USAID reviewed the costs and benefits of adding family planning to PMTCT programs in the 14 African and Caribbean countries participating in the U.S. International Mother and Child Prevention Initiative. The analysis showed that the addition of family planning to existing PMTCT programs is cost-effective, offers HIV-positive women and their children additional health benefits, and can help achieve international development goals (Stover et al., 2003).

Addressing Operational Policy Barriers. Integrating FP/RH and HIV programs requires greater attention to the policies and procedures that govern these programs. To address this need, building on the project's work on Jamaica's Strategic Framework for Reproductive Health that identified integration as a key

issue, POLICY is exploring the feasibility of integration at the parish level. The activity involved assessing client and provider attitudes toward integration interventions and estimating the costs of implementing various interventions. In addition, POLICY conducted a cost-effectiveness study to assess alternative strategies for the diagnosis and treatment of STIs (for more, see Packer et al., 2004; Bollinger et al., 2005).

Uganda is approaching family planning/HIV integration by including family planning as part of VCT, ARV, and PMTCT service delivery protocols; training providers in family planning delivery; and establishing referral links to specialized family planning agencies for services not available in HIV settings (Assimwe et al., 2005).

Highlighting some of the challenges facing full integration, POLICY research found staff shortages, the ability to offer only a limited range of family planning services, and space limitations. Because of these limitations, providers will continue to have to refer those who want clinical methods of contraceptives (such as intrauterine devices) to specialized family planning clinics.

Meeting the Reproductive Healthcare Needs of HIV-positive Women. POLICY has addressed the reproductive health needs of HIV-positive women in South Africa, Swaziland, and Ukraine. For example, in partnership with the International Community of Women Living with HIV/AIDS (ICW), POLICY is strengthening HIV-positive women's policy dialogue and advocacy capacity regarding reproductive health issues. POLICY assisted ICW in conducting a rapid assessment to identify policy and operational barriers to reproductive healthcare access at the clinic, community, and national levels in South Africa and Swaziland; advocacy training is also under way. In Ukraine, POLICY's work with multisectoral partners on the reproductive health needs of HIV-positive pregnant women led to revisions in the country's PMTCT and VCT policies. In Swaziland, the Sikanyekanye ("We are in this together") project brought together representatives from different sectors to research and develop recommendations on reducing barriers to HIV-positive women's access to reproductive healthcare.



REFLECTIONS: LESSONS LEARNED AND FUTURE CHALLENGES

PHOTO CREDIT: CORBIS

An enabling policy environment lays the foundation for effective programs and services for those affected by the HIV pandemic.



REFLECTIONS: LESSONS LEARNED AND FUTURE CHALLENGES



**“We must never lose sight of the truth
that the worldwide HIV/AIDS pandemic is,
first and foremost, a human tragedy.”**

Ambassador Randall Tobias,
U.S. Global AIDS Coordinator

Remarks to the 4th Caribbean Regional Chiefs
of Mission Conference on HIV/AIDS

October 3, 2005

PHOTO CREDIT: PALANI MOHAN

An enabling policy environment is the glue that holds the core elements of effective HIV responses together.

The HIV policy environment has changed dramatically over the past five years. However, with 13,000 new HIV infections a day, the global response to the pandemic is still inadequate. HIV is extraordinarily complex, a factor that has only increased over time. An effective response to the pandemic requires multiple partners working at many levels through a network of entry points. Activists, researchers, donors, and world leaders have all analyzed why the global HIV response has not yet stemmed the spread of the pandemic.

Myriad reasons have been cited, including:

- Inadequate funding
- Insufficient coverage of programs and services
- Competing geo-political issues
- Inability of countries to effectively absorb increased resources
- Human capacity limitations

- Scarcity and paucity of data
- Gender norms, inequality, and violence
- HIV-related stigma and discrimination against people living with HIV and vulnerable groups, such as prostitutes, IDUs, and MSM

As the POLICY Project's body of work demonstrates, an improved policy environment can help address many of the factors that inhibit effective HIV responses. In response to new challenges and emerging opportunities, POLICY has built on its successes in the field, shifted emphasis where appropriate, and pioneered new techniques where needed—resulting in many sustainable policy processes and replicable projects. The following analysis offers reflections on POLICY's lessons learned for addressing key HIV policy issues, with a look ahead to continuing and emerging challenges and opportunities.

POLICY DEVELOPMENT AND IMPLEMENTATION

WHAT WE HAVE LEARNED:

Experience has shown that much more needs to be done to facilitate turning good policy into consistent good practice. In 2005, a quarter century into the pandemic, few countries have effective or adequately financed national strategies and policies. Ownership of national strategies by all stakeholders remains low in many places. Countries that have succeeded in introducing policies often face the challenge of uniform implementation at provincial and local levels. Even as national policies are strengthened, there is increasing urgency to support consistent policy implementation through appropriate funding, operational guidelines, strategies, and programs. Unfortunately, even where strong policy environments exist, the coverage of essential programs and services is barely adequate to have

impact on the course of the pandemic. Multisectoral approaches are rarely implemented effectively. The need remains to build political commitment and assist countries to use improved analytic methods and systems for translating policies into action. Strong leadership and meaningful community engagement are often missing ingredients in national responses.

POLICY has supported policy champions from various groups and sectors to increase their skills in policymaking, analysis, advocacy, and implementation, but much more remains to be done. A central consideration will be how to ensure sustainability of HIV policy and program responses, particularly as countries increasingly move from receiving external technical assistance to taking full responsibility for their national HIV programs. For this reason, POLICY has focused on building capacity of in-country partners and facilitated locally determined policy development.

FUTURE POLICY CHALLENGES AND OPPORTUNITIES:

- Translating policies into improved programs to facilitate greater coverage and impact of services.

- Ensuring that operational guidelines and financing mechanisms are in place to facilitate coverage.
- Addressing policy fatigue and keeping policymakers and other leaders motivated.
- Building capacity across all sectors; as country responses become more complex, the need to carry out policy work and implementation is multiplied—improved methods to scale up country capacity and establish sustainable local policy capacity are critically important for the future.
- Promoting involvement by people living with HIV and other vulnerable communities in the policymaking process, which will require greater capacity building and development of new leaders from within these communities.
- Tailoring prevention, treatment, and care strategies to the local context so that

policies and programs meet the needs of vulnerable groups in the given country, which will often mean tackling sensitive social and cultural issues (e.g., gender inequality, attitudes toward sex and sexuality, illicit drug use).

CENTRAL ROLE OF PEOPLE LIVING WITH HIV

WHAT WE HAVE LEARNED:

Empowering people living with HIV and other vulnerable groups is fundamental to the success of HIV responses. The involvement of people living with HIV represents a significant, yet largely untapped resource in reducing the scale and impact of HIV. In terms of future policy responses, as the momentum for ARV access continues to grow and prevention efforts are reinvigorated, people living with HIV can provide the bridge between prevention and treatment—personalizing the pandemic in places where HIV

Proper attention at the policy development stage lays the foundation for more effective program implementation and scale-up.



POLICY has strengthened the capacity of 11 national and regional HIV-positive people's networks, including the Network of People Living with HIV/AIDS in Kenya.

Policies and programs are significantly improved when people living with HIV and members of vulnerable groups play a leading role in the HIV response.

has been seen by many as affecting only others. For example, the global effort to increase ARV access could be greatly enhanced by encouraging people living with HIV to take the lead in providing health information and supporting adherence to ARVs among their partners and peers.

POLICY has learned that it is difficult, but not impossible, to move involvement from isolated or localized attempts at inclusion toward an integrated and partnership-based approach at all levels. Like many organizations working in HIV, POLICY has struggled with operationalizing the principle of meaningful participation of vulnerable groups. The project has assisted people living with HIV to strengthen specific skills, such as advocacy, working with

the media, and overcoming internal stigma. It also promoted their involvement as leaders, facilitators, planners, and program implementers. These efforts enabled HIV-positive people to participate in policy arenas where they previously had little access, including resource allocation, national policy development, and treatment access. More recently, POLICY's focus has been to empower people living with HIV to become leaders and educators in prevention, treatment, and care, including healthy life skills. In addition, POLICY employs HIV-positive staff across the project and the resulting gains, in terms of approaches developed and groups reached, have been immeasurable (see "In Focus 3" on page 96).

FUTURE POLICY CHALLENGES AND OPPORTUNITIES:

- Placing greater emphasis on building or enhancing organizations led by people living with HIV at grassroots, national, and international levels; this undertaking will require better understanding of how leadership is developed in marginalized communities and greater attention to mentoring HIV-positive women to take on leadership roles.
- Encouraging respect for the contributions made by people living with HIV and other vulnerable groups to the HIV response.
- Increasing participation of people living with HIV as staff in HIV-related organizations (e.g., donors, governments, and service organizations) to

strengthen participation and use of programs by HIV-positive people.

LEADERSHIP AND MULTISECTORAL ENGAGEMENT

WHAT WE HAVE LEARNED:

Effective policy work requires visionary policy champions from across sectors who lead by example, ensuring that the silence surrounding HIV is broken and that HIV responses are inclusive of all people. Strengthening the collective power of leaders and policy champions has been critical to the success of national and community-level responses to the pandemic. The successful, sustainable response needed to confront the pandemic will not come about through a “business as usual” approach; instead, individuals and groups who demonstrate leadership and continuously advocate and move the process forward will make a vital difference.

Leaders must come from all sectors, including government, faith-based organizations, NGOs, the private sector, and vulnerable groups. The need for multisectoral responses grows out of the complex range of health, social, and

political issues that HIV encompasses. POLICY has seen that multisectoral policymaking and planning have been adopted in theory; however, coordinated implementation in practice has been weak due, in part, to resistance from governments, donors, and NGOs. Extensive advocacy and understanding of the costs and benefits are needed to overcome disincentives, particularly in light of increases in funding. Furthermore, there is a need to better understand effective multisectoral engage-

- Developing new methods to strengthen multisectoral structures, to expand membership to new partners and vulnerable groups, and to improve tools for coordination and planning; implementing the “Three Ones” presents a significant opportunity as we move forward.
- Recognizing that strengthening leadership and multisectoral engagement is a continuous, ongoing process, for example, as new politi-

Leaders and policy champions promoting change from within—whether in a government department, a faith-based group, NGO, or a business—are essential for galvanizing HIV responses.

ment and its impact on replicating successful approaches.

FUTURE POLICY CHALLENGES AND OPPORTUNITIES:

- Strengthening leadership by giving leaders and policy champions the skills and evidence to speak with confidence about the realities of HIV and to motivate their constituencies to address HIV.

cians take office, new stakeholders enter the HIV arena, and new workers must be oriented to established policies and guidelines.

RESOURCES AND DATA FOR DECISIONMAKING

WHAT WE HAVE LEARNED:

Successful programs depend on paying proper attention

Programs have greater impact and sustainability when policies consider the best available data regarding resource needs (e.g., funding levels, human capacity), current and desired service coverage, and the extent and impact of the pandemic in the local context.

throughout the policy, planning, and budgeting cycle. Despite the influx of new resources, countries must still plan strategically and set priorities for how those resources can be used most effectively. Country programs that carefully assess resource needs and identify gaps in resources have been in a better position to strategically mobilize internal and external resources to fill those gaps. In addition, the dramatic growth of financial resources for HIV over the past five years has revealed that the capacity within countries and organizations to absorb and effectively use new resources is a significant concern. Building adequate human capacity is already recognized as a major constraint for those countries that are scaling up their programs. This is especially true for interventions, such as treatment programs, that must rely on skilled healthcare professionals. Innovative policy solutions—such as policies to

support healthcare worker recruitment and retention, or operational guidelines that authorize different categories of healthcare workers to provide specific services with proper supervision—can help alleviate some human capacity constraints. However, identifying and addressing resource gaps in responses will continue to require long-term attention, commitment, and planning. POLICY has worked to ensure that strategic planning exercises and models are adapted to and respond to emerging needs, such as resources required for investment in human capacity development or resources needed to sustain reliable access to ARVs.

FUTURE POLICY CHALLENGES AND OPPORTUNITIES:

- Ensuring that planning and budgeting exercises for HIV strategies take into consideration the need to set goals and priorities.

- Establishing mechanisms to coordinate and monitor resource flows from various donor organizations and avoid duplication of effort, especially in the context of the “Three Ones.”
- Working with countries to accurately identify barriers to and solutions for effective scale-up of HIV treatment programs, especially given the existing limitations on infrastructure and human capacity.
- Ensuring equitable access of vulnerable populations to prevention, treatment, and care, which may still be financially or geographically out of reach for many groups.
- Mobilizing in-country resources from across sectors, including the private sector, to help support sustainability, while at the same time working to prevent community-based and grassroots organizations from becoming overburdened.

REDUCING VULNERABILITY

WHAT WE HAVE LEARNED:

The ability to prevent HIV infection and improve the lives of people living with HIV will depend on the extent to which countries and communities meet the needs of the most vulnerable populations. Sadly, people living with HIV may not seek life-sustaining treatment for fear of stigma and discrimination from the community or from healthcare workers. Some HIV-positive women have chosen to breastfeed their babies because of the potential for abuse or abandonment if their status becomes known.

Children of HIV-positive parents have been denied the right to go to school. Prostitutes and their partners and clients are at risk of HIV infection because they do not have the skills, capacity, support, or power to demand consistent condom use.

Policymakers and program planners must understand that prevention, treatment, and care service delivery efforts cannot succeed without also addressing stigma and discrimination, gender inequality, poverty, and the need for policies and programs for youth, orphans, and vulnerable children. The next five years could prove to be a turning point in the global response to the pandemic.

Medical advances and new resources have the potential to dramatically slow the progression of HIV to AIDS, enabling people living with HIV and their families to maintain a higher quality of life for a longer period of time.

However, realizing this shift in the pandemic and averting future infections depends on how policies and programs include and address people living with HIV, women, youth and orphans and vulnerable children, the poor, and vulnerable populations, such as prostitutes, MSM, and IDUs.

Mitigating the factors that exacerbate vulnerability—including stigma, discrimination, human rights violations, gender inequality, and poverty—holds the key for making real inroads in responding to the pandemic. The success of prevention, treatment, and care depends on empowering and meeting the needs of society's most vulnerable populations.

FUTURE POLICY CHALLENGES AND OPPORTUNITIES:

Stigma, Discrimination, and Human Rights

- Continuing to develop evidence-based approaches and tools that highlight the program benefits of reducing stigma and discrimination and promoting human rights; this information can help strengthen political and popular support for needed HIV interventions that may challenge community or societal norms.
- Scaling up successful strategies for reducing stigma and discrimination; this will involve working with community structures (e.g., faith-based organizations, women's groups) to strengthen the inclusion of people living with HIV and their families in community life.
- Shifting societal attitudes toward stigmatized groups,

such as prostitutes, MSM, and IDUs; stigmatizing attitudes drive the pandemic underground, increase HIV vulnerability, and hinder prevention, treatment, and care efforts.

- Creating safe spaces (e.g., networks, inclusive policy-making bodies) for marginalized communities to participate in the response to HIV.
- Safeguarding human rights protections for vulnerable populations in the context of rapid scale-up to, among other factors, ensure informed consent and confidentiality while programs seek to significantly increase HIV testing, especially for women at risk for gender-based violence.
- Protecting the rights of people at risk for HIV infection who take part in clinical trials for vaccines or new treatment and prevention methods.

Gender

- Strengthening leadership of women, especially HIV-positive women, including strengthening positive networks, providing capacity building, and promoting realistic and effective income-generation initiatives—both to reduce HIV vulnerability and increase the ability to cope for those already affected.
- Developing and implementing approaches to monitor gender equity in policies and programs, including participatory monitoring strategies related to quality of care, progress on rights, and budgeting; such approaches are essential to bridge the gap between policy and practice.
- Supporting research into links between gender-based violence and HIV programs.
- Promoting women's equality within traditional, faith-based, and community structures and organizations.

Successful integration requires addressing operational issues and fostering recognition of the FP/RH needs of people living with HIV and vulnerable populations.

- Fostering approaches to integrate gender into national- and local-level government policy processes; this includes supporting gender-focused task forces and reference groups, integrating gender analyses into planning processes, and designing and implementing gender-equitable programs.

Youth and Orphans and Vulnerable Children

- Improving understanding of, and adapting approaches to, the needs of various youth populations—including in- and out-of-school youth, those who are sexually active and those who are not, those who are married and unmarried, and those practicing high-risk behaviors.
- Devising policy responses to address the factors that pressure young people to engage in risk behaviors (e.g., transactional or cross-generational sex).

- Strengthening leadership skills among youth and advocates for youth and orphans and vulnerable children.
- Ensuring that programs for orphans and vulnerable children are given priority in national policies and strategies with appropriate resources and links to support systems; establishing this priority can be particularly challenging in emerging epidemics where the need to address the AIDS orphan crisis does not seem readily apparent.

HIV AND FP/RH INTEGRATION

WHAT WE HAVE LEARNED:

Integrating HIV and FP/RH has several benefits for women and men, most notably reducing unintended pregnancy and the subsequent potential for vertical transmission of HIV.



PHOTO CREDIT: ANITA BHUYAN

Meeting of a group of Indian women who work as community-based distributors of family planning commodities.

Policymakers, program managers, and clients alike recognize that people living with HIV need access to FP/RH programs. Such services, to the extent possible, should be integrated or linked by referral mechanisms. Integrating FP counseling and services into HIV programs can be cost-effective in the long run, though it initially requires investment and revisions at all policy and program levels to ensure that public health clinics can move from a system of separate or stand alone clinical services offered at a site (e.g., antenatal care, immunization clinics) to the integration of appropriate services into clinics (e.g., HIV testing at STI clinics). At the same time, for women and their partners to benefit from such services, considerable work is needed to confront stigma and discrimination at community, clinic, and

broader levels of society to affirm that people living with HIV can choose to be sexually active and still be supported in decisions about wanting to have or delay having children.

FUTURE POLICY CHALLENGES AND OPPORTUNITIES:

- Working with policy champions to promote the beneficial links between HIV and FP/RH programs by taking a “whole person” approach to meeting the needs of HIV-positive and HIV-negative women and men.
- Developing advocacy strategies that promote support among communities, health-care providers, policymakers, and broader society to recognize that people living with HIV can be sexually active and can have or choose not to have children.
- Increasing the leadership role of people living with HIV in devising policies and programs that will promote the reproductive health of HIV-positive people.
- Reviewing policies for opportunities to link HIV and FP/RH programs, particularly HIV counseling and testing and PMTCT; included in this work is identifying or revising policies and guidelines to ensure that integration is supported in national systems of healthcare and facilitates access to services and commodities for HIV and FP/RH.
- Assessing the costs of integration so that policymakers can make informed choices about what aspects of programs can be integrated and how much the initial investment will be to ensure integration from the policy to the program level.



PHOTO CREDIT: COREL

FROM RHETORIC TO REALITY: A MODEL FOR MEANINGFUL INVOLVEMENT OF PEOPLE LIVING WITH HIV

When POLICY began working in Vietnam in late 2002, the HIV-positive community was fragmented with minimal mobilization beyond government-sanctioned and controlled support groups. An effective response will be achieved only by ensuring that the HIV-positive community is in control of its participation. Where there is little or no support for autonomous development and involvement, as was the case in Vietnam until recently, the potential for international actors to shape and direct what should be an indigenous movement is strong. The result is organizations for people living with HIV that are little more than the clients of donors or other funding agencies. As an HIV actor in Vietnam, POLICY believes it has a responsibility to move progressively toward an organizational approach that is a model for meaningful participation of people living with HIV. In the case of Vietnam, supporting meaningful involvement meant working with the emerging HIV-positive community and supporting its leadership to increase representational capacity.

Supporting the HIV-positive community “voice” meant that POLICY staff had to develop relationships of trust with the small but growing number of people living with HIV who are pioneering an independent approach. POLICY provided technical and financial resources, including training in organizational development, regional and international networking, and, more recently, technical and advocacy support for treatment preparedness. In addition, POLICY developed a mentoring system where HIV-positive community leaders are provided with support to become policy advocates and gain experience working within the HIV sector, which required the project to commit organizational resources that can be directed by people living with HIV.

Importantly, POLICY actively recruited people living with HIV as staff members, and currently more than

25 percent of the Vietnam country staff are openly HIV-positive. All positions advertised by the project include a statement encouraging people living with HIV to submit an application. POLICY believes that the active recruitment and employment of those directly affected by the pandemic has been instrumental in the project's ability to increase its overall effectiveness, as well as support meaningful participation in Vietnam.

There are several considerations, both professional and programmatic, that POLICY has had to address and monitor in relation to employing people living with HIV. The first is a commitment to supporting staff when they are ill or need time off. Secondly, the developing nature of the HIV-positive community movement means that the potential exists for recruitment of people living with HIV to undermine the autonomous development of the HIV-positive

sector, particularly if recruitment is by an international agency. Put simply, if HIV-positive staff are recruited from self-help groups, those groups lose their most active members. POLICY addresses this dilemma through commitment to support HIV-positive community self-help development. In a practical sense, the employment of people living with HIV who work alongside other project staff to support self-help and network development improves rather than undermines the strength of the groups and networks the project supports.

POLICY has found that the experiences and expertise of people living with HIV make vital contributions to a more effective response. One example is a media monitoring activity conducted by a staff member in Hanoi, which in less than six months has resulted in the publication of more than 10 articles in the

Vietnamese media. Our HIV-positive staff have also been central to supporting the expansion of the HIV-positive sector and securing more than US\$40,000 in funding from alternative international donors for developing networks throughout Vietnam.

This work is difficult. It is not easy for HIV-positive staff to gain the skills and confidence required to interact with senior government and international actors. That they do this and are able to add immeasurable value is a significant, but generally under-utilized, aspect of HIV responses. In an era of expanding ARV access and efforts to integrate HIV activities across the spectrum of prevention, treatment, and care, the involvement of HIV-positive people—as a sector and as professional members of HIV organizations—is becoming a critically important approach that demands greater support and resources.

CONCLUSION: LINKING POLICIES AND PROGRAMS

In adapting to and influencing the global and country-level policy environments, the POLICY Project identified five pathways or technical focus areas that are essential for creating an enabling environment. These core areas include policy formulation, leadership and advocacy, resources and data for decisionmaking, reducing vulnerability, and multisectoral engagement. If any aspect is neglected, the integrity of the policy environment is compromised. A policy response will not be effective, for example, if it is not based on sound evidence. A policy may be adopted, yet it will be difficult to implement without proper resource allocation or multisectoral support for implementation. A policy that does not consider the needs and views of people living with HIV, who must be leaders in the response, may miss the mark in terms of delivering services to those most in need of treatment and care. All of the pieces must come together to strengthen the policy response.

What makes the policy environment particularly important, including for HIV responses, is the link between policy development and program implementation. Policy development is valuable both as a process and as an outcome. As a process, policies that come about through a participatory, broad-based manner can:

- Build cooperative relationships and networks that will facilitate implementation;
- Educate the various stakeholders of the viewpoints, needs, and assets of other affected groups;
- Encourage consensus on priority issues and approaches;
- Promote ownership and buy-in across sectors;

- Empower those who take part in the process;
- Promote open community dialogue on policy issues and break the silence surrounding HIV; and
- Bestow greater legitimacy on the policy approaches adopted, thereby increasing likelihood of effective implementation.

As an outcome, policies support implementation by:

- Outlining goals, strategies, roles, and responsibilities;
- Serving as evidence of the government's or organization's commitment to addressing HIV;
- Giving authority to various stakeholders to undertake

activities to meet goals and objectives;

- Ensuring continuity and stability in a country's overall response, even though individual leaders or stakeholders may change;
- Improving implementation and enhancing consistency at the service and program delivery level; and
- Establishing mechanisms to protect the rights of various groups, including people living with HIV, vulnerable groups, women and youth, healthcare workers, employees, and so forth.

For these reasons, successful program implementation and scale up—especially of the magnitude required to meet

future HIV prevention, treatment, and care goals—are dependent on creation of enabling policy environments.

The POLICY Project's body of work and achievements demonstrate the diverse ways in which policy environment is integral to the success of HIV prevention, treatment, and care interventions and, ultimately, to the ability of countries to avert future infections and improve the quality of life of those most affected.



ABBREVIATION LIST

| | | | |
|----------------------|--|-----------------|---|
| A² | analysis and advocacy | FY | fiscal year |
| AIDS | acquired immune deficiency syndrome | GIPA | Greater Involvement of People Living with HIV/AIDS |
| APES | AIDS Program Effort Score | GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| API | AIDS Program Effort Index | GNP+ | Global Network of People Living With HIV/AIDS |
| APLF | Asia Pacific Leadership Forum on HIV/AIDS and Development | GTZ | German Council for Sustainable Development |
| APN+ | Asia-Pacific Network of People Living With HIV/AIDS | HEAP | HIV/AIDS Emergency Action Plan (Nigeria) |
| ARV | antiretroviral | HIV | human immunodeficiency virus |
| CBCI | Catholic Bishops Conference of India | ICW | International Community of Women Living with HIV/AIDS |
| CCM | country coordinating mechanism | IDU | injection drug user |
| CGM | Chinese Garment Manufacturers (Lesotho) | KENEPOTE | Kenya HIV-Positive Teachers Network |
| COGAYLESH | Coalición de Organizaciones y Grupos Gay y Lesbianas de Honduras | MANET+ | Malawi Network of People Living with HIV/AIDS |
| CORE | Communities Responding to the HIV/AIDS Epidemic | MCG | multisectoral citizens group (Mexico) |
| CPN+ | Cambodian Network of People Living with HIV/AIDS | MSM | men who have sex with men |
| CPSA | Church of the Province of Southern Africa | MTCT | mother-to-child transmission |
| DPSA | Department of Public Service and Administration (South Africa) | NGO | nongovernmental organization |
| ESA | East and Southern Africa | NYCD | National Center for Youth Development (Jamaica) |
| FP | family planning | PMTCT | prevention of mother-to-child transmission |

| | | | |
|--------------|---|---------------|---|
| RAAAP | Rapid Country Assessment, Analysis, and Action Planning | UNAIDS | Joint United Nations Program on HIV/AIDS |
| REDSO | Regional Economic Development Services Office | UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| RH | reproductive health | USAID | United States Agency for International Development |
| RHAP | Regional HIV/AIDS Program of Southern Africa | USD | United States dollar |
| RN | Recovering Nepal | VCT | voluntary counseling and testing |
| STI | sexually transmitted infection | WARP | West Africa Regional Program |
| TB | tuberculosis | WHO | World Health Organization |



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